OAK RIDGE:

A REVIEW AND AN ALTERNATIVE

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FOREWORD

Oak Ridge is the only maximum security facility for mentally disordered men in the Province of Ontario. Its patients include: those who have been charged with criminal offences and are sent for assessment by the Courts; those who have been found "unfit to stand trial" because of mental disorder; those who have been acquitted of a crime "by reason of insanity"; and those who have been found to be seriously mentally ill during incarceration. It also accommodates, and currently these comprise about half the patients at the hospital, those individuals who have never been formally charged with any criminal offence with respect to their current admission but who are mentally disordered and too violent or unmanageable in ordinary psychiatric facilities.

It has been in operation for over fifty years and was originally constructed along prison lines. Although some changes, structural, administrative and attitudinal, have occurred, especially in the past few years and its central role in the province's mental health and criminal justice systems is undiminished, nevertheless it has experienced serious difficulties including the recruitment of professional staff, attendant staff-management relations, and quality of care. More recently there have been allegations from patients that the hospital violates their rights under the Charter of Rights and Freedoms.

The Committee, struck by the Ministry of Health in February, 1984, to review Oak Ridge and its programmes, recognised at the outset of its task the enormous complexity of the issues and the difficulties inherent in functioning at the junction of the mental health and criminal justice systems. Consequently, the Committee found it necessary to deliberate longer and harder than was initially anticipated.

Throughout the review process, contacts were made with all levels of personnel in the various departments at the Regional Mental Health Centre, Penetanguishene, and at Oak Ridge, though of course it was not practical to interview every patient and staff member individually. Patients and staff were generally very cooperative and candid. Their help was greatly appreciated by the Committee members who were keenly aware not only of the inconvenience imposed by the visits and interviews but also of the feelings of staff about undergoing scrutiny by a panel of outsiders.

The visits to Oak Ridge were carried out at various times. Some consisted of formal tours but, more frequently, they involved detailed investigations of specific units and programs, departments and personnel. Where appropriate, Committee members were permitted to observe meetings of staff and patients, attend conferences and other activities. The Committee extensively reviewed annual reports, administrative program descriptions and other documents relating to Oak Ridge. Clinical records of patients were examined as were reports of internal program reviews of the Admission Unit and Behaviour Therapy Unit, and the hospital's own "Master Plan" for the future development of the facility. Also perused were various previous external reviews of Oak Ridge including that commissioned by the Ministry of Health in 1973, that by the Ontario Ombudsman in 1976, and the various reports by the Canadian Council on Hospital Accreditation. Finally, some Committee members visited selected facilities across Canada, and in the United States and Great Britain which have similar roles and functions to Oak Ridge.

Many individuals external to Oak Ridge and the Ministry of Health were especially helpful in providing information and opinions. These were too numerous to mention individually, though some are acknowledged at various points in the text. Also, invaluable assistance was provided by the staff of the medium secure units and various other facilities to which Committee members made site visits. Although the views of these individuals were gratefully received and carefully considered, the responsibility for this Report is entirely that of the Committee.

In the meetings held by the Committee during and following its review and site visits, many contentious issues were debated at great length before the following final Report was completed, and the members were able to agree with its contents and recommendations. The Committee is aware that, since the review process, some changes which are recommended in this Report have already been made. This, in itself, indicates to the Committee that the Review has been worthwhile. The task has been started; however, a great deal remains to be done.

LIST OF CONTENTS

FOREWORD

A INTRODUCTION 1
- A.1. GENERAL BACKGROUND 2
- A.2. RECENT DEVELOPMENTS 4
- A.3. FORMATION OF THE PRESENT REVIEW COMMITTEE 5

B THE REVIEW 7
- B.1. GENERAL DESCRIPTION OF OAK RIDGE 8
- B.2. THE ROLE OF OAK RIDGE 8
- B.3. THE ADMINISTRATIVE STRUCTURE OF OAK RIDGE 12
- B.4. THE PHYSICAL PLANT 15
  - i. The Building as a Whole 15
  - ii. Physical Security 16
  - iii. Patients' Living Areas 17
  - iv. Recreational and Leisure Facilities 17
  - v. Visitors' and Administration Complex 20
  - vi. Attendant Staff Amenities 20
  - vii. Facilities for Diagnostic and Therapeutic Programs 21
  - viii. Facilities for Educational Programs 22
  - ix. Facilities for Rehabilitative Programs 22
  - x. Chapel 25
  - xi. Pharmacy 26
  - xii. Ward Nurses' Stations, Treatment Rooms, etc. 26
  - xiii. Physical Space for Other Programs and Services 26

- B.5. CHARACTERISTICS OF PATIENTS AT OAK RIDGE 27
  - i. Legal Categories 27
    - a. Warrants of Remand 27
    - b. Warrants of the Lieutenant Governor 28
    - c. Involuntary 28
  - ii. Numbers of Patients 29
  - iii. Immediate Referral Source 30
  - iv. Primary Diagnosis 31
  - v. Most Serious Offence Leading to Admission 32
  - vi. Patients who have had Previous Incarceration in Correctional Facilites 33
  - vii. Previous Admissions to Other Psychiatric Hospitals 34
  - viii. Previous Admissions to Oak Ridge 34
  - ix. Length of Stay at Oak Ridge 35

B.6. THE FOUR PATIENT CARE UNITS 36
- i. Behaviour Therapy Unit (BTU - Wards 07 and 08) 36
  - a. Function 36
  - b. Patient Characteristics 36
  - c. Unit Program 37
  - d. Leadership and Management 41
  - e. Staffing Resources 43
  - f. Use of Medication 44
  - g. Use of Confinement 44
  - h. Ethical and Legal Issues 46
  - i. Length of Stay 47
  - j. Other Issues 47

- ii. Extended Treatment Unit (ETU-Wards 04 and 06) 49
  - a. Function 49
  - b. Patient Characteristics 50
  - c. Programs 54
  - d. Leadership and Management 57
  - e. Staffing Resources 58
  - f. Use of Medication 58
  - g. Use of Confinement 59
  - h. Ethical and Legal Issues 60
  - i. Length of Stay 60
  - j. Other Issues 61

- iii. Forensic Assessment and Treatment Unit (FATU - Wards 01 and 02) 61
  - a. Function 61
  - b. Patient Characteristics 62
  - c. Programs 64
  - d. Leadership and Management 69
  - e. Staffing Resources 69
  - f. Use of Medication 70
  - g. Use of Confinement 71
  - h. Ethical and Legal Issues 71
  - i. Length of Stay 74

- iv. Admission Unit (AU - Wards 03 and 05) 74
  - a. Function 74
  - b. Patient Characteristics 75
  - c. Programs 76
  - d. Leadership and Management 79
  - e. Staffing Resources 80
  - f. Use of Medication 81
  - g. Use of Confinement 81
  - h. Ethical and Legal Issues 82
  - i. Length of Stay 83

B.7. GENERAL MEDICAL AND HEALTH CARE OF PATIENTS 83
- i. Access to Physicians and Nurses by Patients 84
- ii. Supervision of Medical and Nursing Services at Oak Ridge 85
- iii. Dental Services 86

B.8. STAFF RESOURCES..
i. Medicine 86
ii. Psychology.. 86
iii. Research Department 89
iv. Social Work 89
v. Vocational, Recreational and Volunteer 89
Services..
vi. Nursing and Attendants.. 90
vii. Chaplaincy.. 90
viii. Occupational Therapy 92
ix. Teaching 92
x. Legal-Clinical Liaison Officer 92
92

B.9. TRAINING AND QUALIFICATIONS OF ATTENDANT STAFF 93
i. Background 94
a. Medication Course 94
b. Crisis Intervention Course 95
c. Cardio-Pulmonary Resuscitation
Training..
d. First Aid Course 95
ii. Library Resources 95
iii. Barriers to Conducting Staff Education 96
at Oak Ridge ....
iv. Quality Assurance at Oak Ridge 96
v. Nursing Leadership.. 97
97

B.10. ETHICAL ISSUES ....
i. Patient Abuse 99
ii. Use of Patient Teachers 99
iii. Confinement 101
iv. "Lock-ups" for Administrative Reasons 102
v. Visiting Rights 103
vi. Privacy 103
vii. Patients Performing Maintenance Functions.. 104
viii. Censoring of Mail.. 105
105

B.11. THE ROLE OF THE OMBUDSMAN AND PATIENT ADVOCATE 106
i. The Office of the Ombudsman.. 106
ii. The Patient Advocate.. 108

B.12. ROLES OF THE LIEUTENANT GOVERNOR'S BOARD OF REVIEW AND THE CENTRAL ONTARIO BOARD OF REVIEW....... 109
i. The Lieutenant Governor's Board of Review 109
ii. Central Ontario Board of Review.. 111

B.13. PROGRAM DESCRIPTIONS, ADMINISTRATIVE POLICY MEMORANDA, ETC 112

C AN ALTERNATIVE 115
C.1. OPTION 1 - Close Oak Ridge and Rebuild a New Similar-Sized Hospital Nearby 117
C.2. OPTION 2 - Demolish Existing Facility and Rebuild a New Hospital with Approximately the Same Bed Capacity Closer To a Large Urban Centre 120
C.3. OPTION 3 - Demolish Oak Ridge and Rebuild as Two New Facilities Elsewhere 121
C.4. OPTION 4 - CLOSE OAK RIDGE AND REBUILD TWO SMALLER UNITS, ONE AT PENETANGUISHENE AND THE OTHER NEAR A LARGE URBAN CENTRE...... 121
    i. Renovate or Rebuild 122
    ii. Size of the Facility 122
    iii. Development of Medium Secure Facilities 125
    iv. Treatment and Rehabilitation Programing 126
    v. Administrative Structure 127
    vi. Course of Redevelopment 128

D SUMMARY OF RECOMMENDATIONS 129

APPENDICES

A. Site Visits 144
B. Background Materials 146
C. Legal Aspects of Current Living Conditions 149
D. Photographs of Oak Ridge
    Photo 1: Front Gate Oak Ridge 181
    Photo 2: New Visitor's and Administration Complex 182
    Photo 3: Rear View of Hospital 183
    Photo 4: Loading and Storage Areas of Industrial Workshop 184
    Photo 5: Lower Ward Corridor 185
    Photo 6: Signs at End of Ward Corridor 187
    Photo 7: Newly Fitted Shower Stalls 186
    Photo 8: Toilet Facilities in a Patient's Room 188
    Photo 9: Concrete Slab "Bed" 189
    Photo 10: Screened and Barred Window 190
E. Figures
    Figure 1: Administrative Structure, PMHC 191
    Figure 2: Administrative Organization of Attendant and Nursing Staff 192
    Figure 3: Site Plan 193
    Figure 4: Basement Floor Plan 194
    Figure 5: First Floor Plan 195
    Figure 6: Second Floor Plan 196

INDEX OF TABLES viii

INDEX OF TABLES

Tables

Table 1: Oak Ridge Patient Attendance in Exercise Yard, June 1984 19

Table 2: Numbers of Patients From Each Ward at Oak Ridge Employed in Available Work Programs, July 1984 23

Table 3: Numbers of Patient Referrals to Vocational Services and Hospital Services, June 1984 24

Table 4: Legal Status of Patients Resident at Oak Ridge on January 1, 1983-85 29

Table 5: Legal Status of Patients Admitted to Oak Ridge During Complete Calendar Years, 1983-84 30

Table 6: Immediate Source of Referral of Oak Ridge Patients Resident on January 1, 1983-85 31

Table 7: Primary Psychiatric Diagnosis of Oak Ridge Patients Resident on January 1, 1983-85 32

Table 8: Most Serious Offences Leading to Admission to Oak Ridge 1983-85 33

Table 9: Previous History of Incarceration of Oak Ridge Patients 1983-85 33

Table 10: Previous Admission of Oak Ridge Patients to Other Psychiatric Hospitals 1983-85 34

Table 11: Previous Admission to Oak Ridge 1983-85 34

Table 12: Length of Stay at Oak Ridge 1983-85 35

Table 13 Remand Admissions to the Forensic Unit, Oak Ridge Division, Mental Health Centre, Penetanguishene, 1984 63

Table 14: Sources of Mental Health Referral to Admission Unit, Oak Ridge Division 75

Table 14: Nursing and Attendant Staffing, Oak Ridge, July 1984 91

SECTION A

INTRODUCTION

A.1. GENERAL BACKGROUND

As noted in the Foreword, patients held at the present time in the Oak Ridge Division of the Penetanguishene Mental Health Centre include both those who have been involved in crime and those who have not. However, this was not always the case. Individuals judged to have been mentally ill at the time they committed an offence were first sent to Penetanguishene in 1933 when the Criminal Insane Building was built for 150 patients. In those days patients lived out their lives at the hospital with little hope of release and, consequently, in 1957, Oak Ridge as the building became known, had to be enlarged to accommodate 300 patients. Then in the early 1960's, promising new treatments in use at the hospital prompted the medical superintendent to explore the possibility of transferring some patients who had recovered to less secure hospitals. The idea took root and, in 1967, the Lieutenant Governor's Advisory Board of Review was introduced to oversee the process.

In the late 1960's and early 1970's, Oak Ridge began attracting world-wide attention with its Social Therapy Program.[1] Patients sent to institutions like Oak Ridge are often extremely difficult to manage; any approach which might advance their treatment naturally arouses interest. The underlying philosophy of the Social Therapy Program was that mental illness is a form of disturbed communication which can best be resolved by means of therapeutic interactions between patients. The Program was organized on four wards, each with its own specialized emphasis. On the admission ward new patients were expected to study papers on group therapy and interpersonal interaction. Study groups on these topics were run by patient-teachers (patients sufficiently advanced in the program to be entrusted with this role) who monitored the patients' progress in conjunction with the ward staff. This ward also accommodated a special program for the management of patients who presented acute discipline or management problems - the Motivation, Attitude and Participation (MAP) program. Patients progessed to a second ward which was highly organized as a system of patient committees emphasizing the responsibility which the patient community assumed for the behaviour of its members. The third ward provided one of the most singular therapeutic enterprises in the whole Program. Among its features was the "total encounter capsule" in which patients were involved in confrontation in a specially-constructed room isolated from the rest of the ward. Psychotic patients were not usually prescribed anti-psychotic medication but simply supervised by other patients and staff on two of the foregoing wards. Some patients volunteered to receive various drugs including LSD, scopolamine, amphetamine and alcohol in an attempt to break down the psychological barriers they had erected to avoid dealing with their abnormal modes of thinking and behaviour. The final ward was a maximum privilege area from which patients attended various work programs in other parts of the building. This ward either prepared the patients for discharge or gave them respite from the more intensive components of the Program.

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[1] For a fuller discussion, from which this description is abstracted, see Quinsey, V.L. "Long Term Management of the Mentally Abnormal Offender," in Mental Disorder and Criminal Responsibility, edited by Hucker, S.J., Webster, C.D. and Ben-Aron, M.H., Butterworths: Toronto, 1981.

In 1976, the Office of the Ontario Ombudsman commissioned a report[1] specifically on the Social Therapy Program. It should be noted that this report was written at a time when the Program continued to maintain an international reputation. The report was generally favourable to the Program. The reviewers pointed out that Oak Ridge had the lowest staff-patient ratio of any psychiatric hospital in the province and that one of the advantages of the Program, they believed, was its ability to maintain itself with minimal involvement of professional staff while placing heavy reliance on patients and attendant staff. The reviewers did not comment adversely about the practice of coercing patients into treatment but noted that staff and patients involved in the Program were enthusiastic about it, as were many professional and lay people outside the hospital.

At the present time, the Social Therapy Program has been all but disbanded, leaving behind only remnants on some of the existing wards. Also, compared with the interest and enthusiasm of a decade ago, recent years have witnessed much more critical comments about the hospital, its treatment programs and its living conditions. Attitudes and practices regarding coercive treatments have changed and are under very serious challenge. Not only have the patients and their legal counsel become increasingly critical of the hospital's use of coercion but professionals and others outside the system have expressed misgivings.

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[1] Evaluative Study of the Social Therapy Unit, Oak Ridge Division, Penetanguishene Mental Health Centre by Drs. Butler, Long and Rowsell, 1976.

A.2. RECENT DEVELOPMENTS

Oak Ridge has had a history of difficult management-labour relations culminating in a "lock-out" of professional staff by attendants in 1978. In the wake of this, a new Administrator and Medical Director were appointed by the Ministry of Health. Since the arrival of this new administrative team, some distinct changes have been effected at Oak Ridge. In May, 1983, the hospital was reorganized into four 75-bed units, replacing the two previous 150-bed units (one of which was the Social Therapy Unit already described, the other, the Activity Treatment Unit). Attempts have been made to reduce the size of the patient population, generally by enforcing greater control than was previously the case, over the inappropriate transfer of patients civilly committed under the Mental Health Act, whose numbers had increased over recent years. With this intention, the Ministry of Health, Mental Health Area, began screening admissions. A new visiting area and administrative office complex was completed in June, 1983. Following these changes, female attendants were introduced at Oak Ridge for the first time in its history. The recently reorganized units have begun to be subjected to reviews of their programs by a subcommittee of the Professional Advisory Committee, Penetanguishene Mental Health Centre. To date, the Behaviour Therapy Unit and the Admission Unit have been so reviewed.

In 1982, a joint management-union Quality of Life Steering Committee was formed under the auspices of the Centre for Quality of Working Life, Ministry of Labour, and a consultant was appointed. Among the issues addressed were the attendants' shift schedules, absenteeism, living conditions and patient-treatment programs. The project was formally evaluated after one year and, although variable success was reported, it was deemed worthy of continuation.

Two long-detained patients in the Social Adaptation Treatment Program made complaints in 1982 through their legal counsel alleging that, among other matters, this program infringed on their personal rights and freedoms. The program had been developed by the hospital in recent years for a small group of patients who had proceeded through, but not benefitted from, other available programs and were considered by the staff to be difficult to manage. The allegations were investigated in 1983 by a consulting forensic psychiatrist at the request of the Ministry of Health. In the report, which was submitted to the Ministry of Health in February of that year, it was recommended that a further, more comprehensive, review of programs and other relevant issues at Oak Ridge be undertaken. This recommendation paralleled the move within Oak Ridge, referred to earlier, in which the newly organized units had undergone internal program reviews.

In September, 1983, the administration of Penetanguishene Mental Health Centre was granted permission by the Mental Health Area of the Ministry of Health to proceed to develop a "Master Plan"[1] for the future of Oak Ridge. The plan was submitted to the Ministry in May, 1984.

A.3. FORMATION OF THE PRESENT REVIEW COMMITTEE

Over a decade ago, in 1973, the Ministry of Health had appointed an external review committee which made recommendations for Oak Ridge and the system of which it forms a part[2]. Two particular problems at Oak Ridge were highlighted in that report: overcrowding and the mixing, in the same facility, of mentally ill patients who had been involved in crime[3] with civilly committed patients who had not[4].

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[1] Task Force Report on the Reorganization of Oak Ridge, April 25, 1984.

[2] Task Force Report on the Oak Ridge Division, Mental Health Centre, Penetanguishene, 1973.

[3] That is, patients who have been found "unfit to stand trial" or "not guilty by reason of insanity" in a court of law or who have been transferred from the prison system because they were deemed in need of psychiatric treatment. These patients are held at Oak Ridge on a Warrant of the Lieutenant Governor, or, in the case of most prison transfers, under the Mental Health Act.

[4] That is, those who have been certified under the provincial Mental Health Act as suffering from a mental disorder, and, as a consequence of which, have shown themselves to be, or are thought to be, dangerous to themselves or others and who have not been manageable in more open facilities elsewhere in the province.

The present Committee was appointed early in 1984 and held its first meeting in March of that year. Most of the site visits by the Committee members to Oak Ridge, as well as to other similar facilities elsewhere in Canada, in the United Kingdom and the United States, took place from the spring of 1984 over approximately one year. The Committee met regularly to discuss progress reports, field notes, and other materials. The terms of reference to be addressed in the Report were:

1. To assess the suitability and appropriateness of a maximum security environment for patients of differing legal status;
2. To comment on the appropriateness of available programs for patients;
3. To assess the roles of the members of the treatment team and to comment on the ratio of professional to ward staff;
4. To outline the elements of an appropriate program evaluation process;
5. To determine whether the rights of all patients at Oak Ridge are respected in all treatment programs.

SECTION B

THE REVIEW

B.1. GENERAL DESCRIPTION OF OAK RIDGE

Oak Ridge is the sole maximum secure psychiatric facility for men in the Province of Ontario, and is administered by the Ministry of Health. It is important, in order to understand some of the complexities of the hospital's problems, to appreciate that Oak Ridge is but one large division of the larger Penetanguishene Mental Health Centre, the other division being the Regional Mental Health Centre. The latter functions like all other provincial psychiatric hospitals and has its own catchment area. On the other hand, Oak Ridge has a specialized role within the Ontario Mental Health System and patients are admitted to it from all psychiatric regions in the province. As well, there are occasionally patients from other provinces. In 1983, the Regional Division, Penetanguishene Mental Health Centre, had a bed capacity of 244, whereas that of Oak Ridge was 298. Efforts have recently been made to reduce the number of beds at Oak Ridge.

Penetanguishene Mental Health Centre is located on the South shore of Georgian Bay in Penetanguishene, about three kilometers from the downtown area, and is approximately five kilometers away from Midland, a slightly larger community. Population in this area swells considerably in the summer months due to a vigorous tourist industry.

Oak Ridge itself is divided into four patient care units. The building is two-storied (see photographs in Appendix D, p.181) and is laid out in such a way that each unit has an upper and lower storey.

B.2. THE ROLE OF OAK RIDGE

In theory all patients admitted to Oak Ridge have been assessed by the referring source as requiring accommodation in conditions of maximum security. These sources consist of the criminal justice system and the mental health system.

In the first category are included patients who have been remanded by the Courts for assessment with respect to pretrial issues such as fitness to stand trial and criminal responsibility, although, sentencing recommendations may also be provided. Such referrals may be made under the Criminal Code of Canada

(Warrants of Remand) though such remands can also be made under the Mental Health Act[1]. The patients are usually remanded to Oak Ridge because they have been deemed by a Court to need maximum security containment though, as will be seen in Section B.6.iii. (p.61) this is not always the case. A much larger group of patients have been sent to Oak Ridge from the criminal justice system consisting of men found by a Court to be either "unfit to stand trial" because of mental disorder or "not guilty by reason of insanity". These patients are held for indefinite periods on Warrants of the Lieutenant Governor (WLG). Their continued detention or their release to other facilities is monitored and regulated by the Lieutenant Governor's Board of Review (see Section B.12.i., p.109). The Ministry of Health has little influence over these referrals although the hospital staff may express doubts about their appropriateness. A final group of referrals from the criminal justice system includes those prisoners who have been serving a sentence in either a federal penitentiary or provincial reformatory, who have been certified under the provincial Mental Health Act and whose mental disorder could not be managed in the correctional environment.

A number of observers of the Ontario mental health system who were interviewed by the Committee indicated that the services of Oak Ridge are often misused. It was pointed out, for example, that there is no systematic method of referring patients on Warrants of Remand to Oak Ridge. The same criticism can be applied with respect to most of the other psychiatric facilities which receive such patients. There is clearly need for a central coordinating policy and a bureau to allocate such referrals to an appropriate facility. Until such a central regulating mechanism is in place, the flow of patients into Oak Ridge, into medium security units elsewhere in the province, and into the various forensic assessment units, will continue to be as haphazard, inefficient and likely costly, as at present.

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[1] Mental Health Act, R.S.O 1980, c.262, s.15.

RECOMMENDATION 1

The Committee recommends that a central coordinating policy and bureau be developed to allocate patients referred by the Courts on Warrants of Remand to an appropriate assessment facility.

A further major problem for Oak Ridge is the ever-increasing numbers of Lieutenant Governor's Warrant patients,[1] some of whom are not readily treatable. It should be recalled that patients who are found "unfit to stand trial" or "not guilty by reason of insanity" are sent to Oak Ridge not necessarily because a hospital staff member has recommended it, but because the Courts, which are part of the criminal justice system, have made a decision which results in this disposition. Thus individuals who suffer from mental disorders for which the psychiatric and allied professions have, at present, little to offer in the way of treatment may enter the mental health system on Warrants of the Lieutenant Governor. The hospital is, therefore, at a loss as to what to do with them. Among this group, for example, are patients diagnosed as "psychopathic personalities" or who have serious sexual anomalies. Complicating matters, the Lieutenant Governor's Board of Review has relatively few placement options available to it. Many individuals who were interviewed by the Committee believe there is a need to increase the number of medium secure units and community hostels within the mental health system. Committee members visited existing medium secure units in Ontario and hospitals where others are planned. It was clear that coordination of the medium secure units with Oak Ridge is not satisfactory. Further, the medium secure units function not only for patients on Warrants of the Lieutenant Governor who have been transferred from Oak Ridge, but also for patients on Warrants of Remand from the courts and for other patients who cannot be managed in the more open wards of their hospitals. This issue is discussed further in Section C of this Report. The Committee is of the opinion that the role and functions of the medium secure units must be clarified before the numbers of such beds are increased. Without such careful deliberation, the Committee believes there is a serious risk that existing problems at Oak Ridge, to be discussed subsequently in this Report, would be replicated in the medium secure units.

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[1] See Rice, M. E., "Medium and Maximum Security Units for Psychiatric Patients in Ontario", unpublished manuscript, Mental Health Centre, Penetanguishene, 1985.

RECOMMENDATION 2

The Committee recommends that before the number of medium secure unit beds is increased, the Ministry of Health clarify, as soon as possible, the expected roles and functions of such units.

RECOMMENDATION 3

The Committee recommends that once the roles and functions of the medium secure units have been clearly defined, the number of beds in such units be increased if necessary.

The second category of individuals admitted to Oak Ridge is comprised chiefly of those civilly committed patients who have been assessed as "unmanageable" at other mental health facilities. The characteristics of patients in this group are also described elsewhere in this Report (see Section B.5., p.27), although in general it can be stated that they are both mentally disordered and judged by the referring source to require a maximum-security setting in order to protect themselves or others from harm. Patients in this category may be discharged either at the discretion of the responsible physician or by the Central Ontario Board of Review (see Section B.12.ii., p.111). These involuntary patients under the Mental Health Act appear often to be sent to Oak Ridge because of inadequate facilities elsewhere. The Committee's investigations indicated that Toronto, in particular, has insufficient facilities for dealing with seriously unmanageable mentally ill patients. Several observers reported that this has been more obvious since the closing of Lakeshore Psychiatric Hospital which contained a medium secure unit. That which was opened at Queen Street Mental Health Centre does not appear to have fulfulled the same needs. It was also noted that Oak Ridge seems to be one of the few facilities within the mental health system which always has beds available. This has made it easy to transfer patients to Oak Ridge who probably should not have been sent there at all. In Section C of this Report alternatives to this state of affairs are proposed and discussed.

From the foregoing it can be seen that patients at Oak Ridge derive from sources which are the responsibility of a number of ministries and government agencies. Specifically, the Provincial Ministry of Correctional Services and The Federal Correctional Service of Canada are primarily responsible for sending mentally ill inmates to Oak Ridge. The Courts remand offenders for assessments and refer on Warrants of the Lieutenant Governor, those found "unfit to stand trial" or "not guilty by reason of insanity". The body of law relating to the detention and care of these patients is extensive and complex and its administration necessitates far better integration and coordination than currently exists. The relevant ministries and agencies do not appear to have tackled the system-wide organizational task with sufficient vigour. This requires high-level continuing discussion between officials of the Ministry of Health with colleagues from the Ministry of the Attorney General, Ministry of Correctional Services, Ministry of Community and Social Services and The Correctional Service of Canada. It also requires an organizational body to effect long-term planning as well as allocation of existing resources. Similar proposals have been made previously in both the Report to the Ontario Council of Health (1979)[1] and the Heseltine Report (1983)[2] which discuss similar bodies in other jurisdictions.

RECOMMENDATION 4

The Committee recommends the establishment of a high-level inter-ministerial body responsible for the overall planning and coordination of resources and service delivery to mentally abnormal offenders.

B.3. THE ADMINISTRATIVE STRUCTURE OF OAK RIDGE

Figure 1, p.191, illustrates the administrative structure of Penetanguishene Mental Health Centre as a whole. The Hospital Administrator is responsible directly to the Ministry of Health, Mental Health Area. All departments of the hospital, including Oak Ridge, report to him either directly or through the Medical Director or Assistant Administrator. Community involvement in the hospital's function is now ensured through the recent appointment of a Community Advisory Board. Penetanguishene Mental Health Centre also has a Management Advisory Committee which reports to the Administrator. Oak Ridge has an Inter-Unit Committee which meets on alternate weeks, except over the summer, and which reports to the Management Advisory Committee. The Inter-Unit Committee appears to function primarily as a forum for information exchange. Membership of the Inter-Unit Committee includes: the Administrator, Medical Director, Director of Nursing, Chief and Assistant Chief Attendant, four Unit Directors, Legal-Clinical Liaison Officer and Public Relations Officer (as secretary). It was reported that attendance at these meetings is variable and some strategic individuals are seldom present.

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[1] Task Force Report to the Ontario Council of Health, 1979.

[2] Towards a Blueprint for Change: A Mental Health Policy and Program Perspective by G. F. Heseltine, December, 1983.

However, this Committee is as close as Oak Ridge itself comes to having any overall, autonomous administrative body with involvement of professional as well as attendant staff. It was pointed out that there is a widespread perception at Oak Ridge, one supported by the Committee's observations, that Oak Ridge is operated essentially on a day-to-day basis by the Chief and Assistant Chief Attendant. It was stated, for example, that the morning reports from Oak Ridge to the Administrator, emanate from the Chief and Assistant Chief Attendant, rather than from a clinician-administrator. It was also noted that there are no Oak Ridge based administrators above the Chief and Assistant Chief Attendant and the four Unit Directors. All the senior administrative staff, including department heads (psychology, nursing, social work and so on), are located at the Regional Mental Health Centre. A number of patients and staff at all levels noted that this tends to result in administration by "remote control" and an absence of regular support and guidance for Oak Ridge staff whose task is difficult and complex.

RECOMMENDATION 5

The Committee recommends that Oak Ridge have its own autonomous administrative structure.

The Committee is also firmly of the view that Oak Ridge requires an Executive Board to whom the Administration would be responsible and which would oversee the operations of the hospital. The Committee suggests that such a Board consist of, in addition to the Administrator and Clinical Director, representatives from the legal and mental health professions and the Ministry of Health.

RECOMMENDATION 6

The Committee recommends that an Executive Board be appointed to oversee the operations of Oak Ridge, responsible to the Ministry of Health.

Figure 2, p.192, illustrates the administrative hierarchy of the attendants and nursing staff at the time of the Committee's visits. It should be noted that many of the attendant staff were very unclear about this organizational model. Although on the surface, the arrangement appears fairly logical and appropriate, the Committee draws attention to the fact that attendant staff are ranked separately from the registered nurses (R.N.) with the exception of the supervisor on one of the wards who has this qualification. The Committee realizes that most of the attendant staff are registered with the College of Nurses of Ontario as Registered Nursing Assistants (R.N.A.) yet thinks it is necessary to point out that the attendants' role and training, as seen in the day-to-day operations of Oak Ridge, is primarily custodial and bears little resemblance to nursing activities at other psychiatric hospitals in the province. Thus, the administrative chart does not clearly reflect the limited nature of the training of R.N.A. attendants and their traditional and primarily custodial role (see Section B.9., p.93). In fact, the term "attendant" is confusing. The Committee suggests that it be replaced by the title "nurse" where qualifications are appropriate. Other staff should be referred to as "security aides".

RECOMMENDATION 7

There should be a clearer distinction in the Oak Ridge administrative organization between staff whose role is primarily related to security functions

and those whose role and training is appropriate to nursing care. The title "attendant" should be abandoned and those staff without nursing qualifications redesignated as "security aides".

B.4. THE PHYSICAL PLANT

B.4.i. The building as a whole

Now fifty years old, the building was modelled after a maximum security prison with emphasis on bars, locks and high wire fences; yet it is expected to function as a hospital. The one recent attempt to improve the building is the new visitors' and administration complex (see photograph 2, p.182).

Ventilation at Oak Ridge is simply through open windows and the temperature control was uniformly regarded as insufficient. Patients described feeling excessively cold in the winter time and too hot in the summer. Lighting is somewhat dim, though on the upper floors the sky-lights make illumination a little brighter. The physical layout of the rooms on the wards makes it very difficult for patients to have any kind of privacy and noise can sometimes be obtrusive. Overall the place is most unattractive. A number of safety hazards were noted. For example, sharp edged doors on which patients could harm themselves were noted.

The prison-like architecture of Oak Ridge is oppressive and, in the Committee's view, completely unsatisfactory for a hospital environment. It emphasizes the security aspect and makes assessment, diagnosis and treatment clearly secondary issues.

The existing structure is maintained with difficulty. At times when the Committee visited, there were maintenance staff carrying out repairs and renovations. For example, on the Behaviour Therapy Unit (BTU), new shower stalls were being installed. Oak Ridge is in a poor state of repair, perhaps no different from other older psychiatric facilities, but nevertheless the Committee believes that it is pointless investing more money into maintaining it and the efforts must be directed towards rebuilding in stages.

Certain units are essentially cleaned by patients with very little help from hospital staff. This arrangement leaves a lot to be desired with respect to cleanliness. A number of patients noted that there tends to be involvement of outside cleaning staff at times when hospital accreditation panels are due to visit.

RECOMMENDATION 8

The Committee recommends that the building be replaced in stages by a more modern, purpose-built facility or facilities.

B.A.ii. Physical Security

The physical security aspect of Oak Ridge is, as already noted, paramount, and the rarity of escapes, absence of hostage takings and relative infrequency of suicides, is a record of which the staff is proud. Perimeter security is maintained by a high chain-link fence enclosing a large yard area for patient exercise and games. The two-storied building itself is highly secure with windows barred and screened. Entry for visitors and staff is through the double front gate (see photogragh 1, p.181). The wooden front door opens immediately onto a metal barred door. Once this is entered by key, the visitor arrives in a receiving area where credentials are checked, photographs taken and necessary searches are conducted. The offices of the Chief and Assistant Chief Attendant and the security staff, who monitor T.V. cameras scanning the yards and perimeter of the facility, are entered through this area. Visitors sign a ledger indicating the nature of their business and, if pertinent, the patient or patients to be interviewed. An unfamiliar visitor will wait to be escorted to his or her destination by an attendant after passing through a second gate, again opened by key. Keys to the locks of the two barred front doors are held only by security staff.

The individual wards can be entered without keys, though access to administative and other offices is restricted by locks. On the wards, patients are accommodated in individual rooms which in appearance are more like prison cells. Some are open barred, others are of heavy metal with a window at eye level and a tray port.

B.A.iii. Patients' Living Areas

There are eight wards. Each consists of a long corridor with patient rooms on either side. Rooms are approximately ten feet by eight feet with a single barred and screened window.

Conditions on the wards are generally desolate and primitive. On some of the wards the patients sleep, according to staff as a safety precaution, on a bleak concrete slab (see photograph 9, p.189) and it is only the better behaved patients and consequently the more privileged, who are able to have some personal belongings in their rooms. Very few have their own portable T.V.'s, stereo equipment, etc. All the patients' rooms at Oak Ridge are virtually identical except that some are more spartan than others.

Patients complained of the indignity of having to use toilets and showers, which for the most part are not designed to afford privacy, in front of visitors and female staff.

RECOMMENDATION 9

The Committee recommends that patients' rooms, wherever possible, afford adequate privacy.

RECOMMENDATION 10

The Committee recommends that patient accommodation provide graded levels of physical security.

B.A.iv. Recreational and Leisure Facilities

Oak Ridge has no gymnasium or proper sports apparatus. The absence of such facilities is extraordinary considering that the hospital houses mainly physically healthy young men. Committee members noted that many more recreational amenities are available to prisoners in most maximum security penitentiaries than to Oak Ridge patients. The exercise yards are spacious enough (see photograph and site plan, p.183 and p.193) but used far too infrequently and, when they are used, the staff generally function to monitor the security. It is worth emphasizing here that, apart from the annual staff-patient baseball game, interaction between staff and patients does not occur in the yards and staff are not encouraged to join in patient-related activities. Table 1, p.19, gives an indication of their use over a period of time during which the Committee visited.

RECOMMENDATION 11

The Committee recommends that the staff-patient ratio be increased to allow more frequent outdoor exercise opportunities for patients.

RECOMMENDATION 12

The Committee recommends that attendant staff be trained and encouraged to participate with patients in their recreation.

On the wards themselves T.V.s are available in the sitting room but only at specified periods. Several patients complained that staff tend to turn the set to whichever programs they want to watch. There was also a complaint that "smoke eaters" (ventilators) in these rooms are rarely used because their noise drowns the sound of the TV. On most wards, movies and library facilities are privileges which have to be earned through good behaviour.

Ward routines are often so regimented that actual leisure time seemed, to the Committee, to be somewhat restricted. However, few patients actually complained of lack of leisure time, but rather the lack of facilities or restrictions on facilities that are available. They further objected to the fact that, ostensibly because of staff shortages, those who choose not be involved in ward leisure activities or attendance at yard were locked up in their rooms.

The physical plant is gloomy and discouraging even on a nice day, what it must be like never to be let outside, as in bad weather, is difficult to imagine. A recreational complex is simply a humane component in any large institutional program. At Oak Ridge the need for such a facility is urgent.

TABLE 1: OAK RIDGE PATIENT ATTENDANCE IN EXERCISE YARD, June 1984[1]

Date	With Recreation Staff Present	Without Recreation Staff Present	Total
1	82	64	146
2	-	-	-
3	-	-	-
4	91	73	174
5	117	93	210
6	178*	166*	344
7	153	70	223
8	87	80	167
9	79	59	138
10	-	147	147
11	82	78	160
12	99	130	229
13	58	-	229
14	103	127	230
15	86	86	182
16	101	161	262
17	-	78	78
18	85	63	148
19	76*	131	207
20	159	-	159
21	118	69	187
22	87	80	167
23	147	162	309
24	-	151	151
25	79	84	163
26	89	92	181
27	94	-	94
28	68	88	156
29	70	83	153
30	118	-	118

* Yard 4 in use.

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[1] Information provided by Vocational/Recreational/Volunteer Department, RMHC, Penetanguishene, July, 1984.

RECOMMENDATION 13

The Committee recommends that the deficiency of recreational amenities be rectified by giving this aspect very high priority in plans for rebuilding the facility.

B.A.v. Visitors' & Administration Complex

The Visitors' and Administration Complex is the most recent addition to the Oak Ridge building. It was completed in 1983. From the outside, despite its new appearance, it is as stark as the rest of the building (see photograph 2, p.182). But inside it is spacious, light and modern. On the lower floor are tables and chairs in a sitting area for patients and staff. Usually patients may be seen by their relatives, lawyers and others in this area under television surveillance by staff outside. There is also a refreshments counter. Staff and patients both use this complex and some patients complained that, though intended for their visitors, sometimes other activities may usurp this function. For example, staff use it for their coffee breaks and also part-time employees use it as a waiting area from which to be called to duties. Staff also use the visiting area to interview patients or conduct testing. On the second storey of this two-storey complex are a conference room and staff offices. Staff in these offices have, because of its location, limited access to ward staff and also, more importantly, to patients. It should be noted here that the Chief Attendant and his Assistant are neither located near patients nor their subordinate staff, the ward attendants. Nor are they placed within the professional-administrative staff office area on the upper floor of the visitors' complex. Whatever the reason for this arrangement, the Committee views it as unfortunate since it is likely to interfere with communication amongst these groups.

B.A.vi. Attendant Staff Amenities

Staff indicated that provision of amenities for attendants is negligible. For example, attendant staff have no lockers for their personal effects. They usually eat their meals on the wards as there is no staff dining room at Oak Ridge. As well, there is no recreational area, such as a lounge, for the staff. Indeed, the only area, other than the wards, where staff were observed to congregate for coffee breaks and the like, was in the patients' visiting area.

Reference was made in Section A.2. (p.4) to the Quality of Working Life program at Oak Ridge. Although the intention of this process, among other matters, is to assist and improve work satisfaction among the staff, the Committee noted that the lack of staff amenities has not been identified as a pressing issue. Nevertheless, attendant staff amenities are of great importance in enhancing morale and are a feature of more modern facilities which impressed members of the Committee on visits.

RECOMMENDATION 14

The Committee recommends that the Ministry or its agents discuss with Oak Ridge attendant staff representatives, the amenities which should be incorporated in the design of a new building.

B.4.vii. Facilities for Diagnostic and Therapeutic Programs

Facilities for physical examinations are unsatisfactory on most units though on Ward 01 of the Forensic Unit, a new doctor's examining room was being constructed out of two patients' rooms. Ambulatory patients in need of a physician's services are seen in the dispensary. However, when necessary, the doctor attends the wards with a registered nurse. The ward setting is not conducive to interviewing patients because of physical restrictions, such as limited patient privacy, poor lighting and other factors.

Similarly, the limitations of space on the wards makes it difficult to have specific rooms set aside for group therapy and the like, and the facilities which are available often serve for other purposes. Group therapy sessions are held in the "sun rooms" or other rooms at the end of each ward. Private consulting or counselling rooms are virtually non-existent. Staff reported that visiting consultants for the Review Boards and others frequently complain of the lack of adequate private rooms for interviewing, let alone for other therapeutic interactions.

RECOMMENDATION 15

The Committee recommends that ample facilities for diagnostic and therapeutic purposes be made available in plans for rebuilding Oak Ridge.

B.A.viii. Facilities for Educational Programs

One classroom is available in the basement of the building. It is equipped with only the most basic necessities for its purpose. In the Committee's view educational facilities and programing are underdeveloped and inadequate.

RECOMMENDATION 16

The Committee recommends that much greater emphasis be placed on educational programing at Oak Ridge and that facilities be included in plans for rebuilding the hospital.

B.A.ix. Facilities for Rehabilitation Programs

Patients who are able to do so, work in various industrial workshop settings or perform maintenance and related functions within the hospital (see Table 2). For example, there is a workshop for refinishing furniture, another for upholstering (which also manufactures untearable gowns and blankets for use at Oak Ridge and other hospitals), and another where wooden pallets (skids) are made. Other activities include assembly work, lathe work and pottery. The "Ball Shop" was formerly for the manufacture of baseballs, but is now used for packaging and other general contract work. The Activity Centre serves approximately 25 patients and the "Ball Shop" another 25. In addition to the recreational staff, there are six attendants regularly assigned to the Activity Centre and Ball Shop.

Referrals to the Vocational Services and Hospital Services programs for June 1984 are given in Table 3. There is a low referral volume from the Extended Treatment Unit (ETU, Wards 04 and 06) but this was interpreted by staff as indicating that few new patients transferred to the ETU had not previously been involved with Vocational and Hospital Services.

TABLE 2: NUMBERS OF PATIENTS FROM EACH WARD AT OAK RIDGE EMPLOYED IN AVAILABLE WORK PROGRAMS, JULY, 1984.[1]

	WARD								
	01	02	03	04	05	06	07	08	TOTAL
VOC.REHAB SHOP	1		3	19		8		2	33
ACTIVITY CENTRE						1	3	19	23
BALL SHOP			2	2		11		9	24
KITCHEN				1		1			2
CLEANERS			2	4	1			1	8
PAINTERS						4			4
LAUNDRY				1					1
ON WD. WORKERS			1						1
TYPING & PRINTING			3						3
PHOTOGRAPHY					2 pt. time				-
FRONT OFFICE							1		1
OUTSIDE WORKERS				3		1			4
PATIENT TEACHERS	5	1	6		5				17
TOTALS	6	1	17	30	6	26	4	31	121

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[1] Information provided by Vocational, Recreational, Volunteer Department, RMHC, Penetanguishene, July, 1984.

TABLE 3: NUMBERS OF PATIENT REFERRALS TO VOCATIONAL SERVICES AND HOSPITAL SERVICES, June, 1984[1]

	WEEK					
	1	2	3	4	5	TOTAL
FORENSIC UNIT		1	1			2
ASSESSMENT UNIT		2		1	1	4
EXTENDED TREATMENT UNIT						0
BEHAVIOUR THERAPY UNIT	2		2		4	8

TOTAL NUMBER REFERRED = 14 (ALL ACCEPTED)

Some Rehabilitation staff indicated that it is often difficult to obtain contract work in an area where there is high unemployment in the community. However, others stated that work is available but may seem too boring and repetitive for many patients. Paradoxically, they also pointed out that patients referred in recent years have been more mentally impaired than in the past and that consequently some of the activities formerly carried out in this department now run less efficiently.

The Committee observed that staff in the Rehabilitation Department operate with the most limited facilities. Not only is the range of activities restricted but conditions are poor. It was noted that noise and dust levels were excessive with no evidence of the wearing of personal protection devices. The available ventilation system was clearly not operating efficiently at the time of the Committee's visit. Other jobs which patients perform in the Rehabilitation and Vocational Therapy Department include: laundry work; cleaning hallways, some ward corridors, offices and some other parts of the building; assisting in the preparation, serving and distribution of food; and cleaning kitchen areas, utensils, dishes and so on. Patients whom staff regard as trustworthy may perform cleaning functions, run errands, and assist with shipping and receiving goods. A very few may even work outside the secure perimeter receiving and removing material from the industrial workshops, cleaning the hospital grounds and removing snow.

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[1] Information provided by Vocational/Recreational/Volunteer Department, RMHC, Penetanguishene, July, 1984.

Although the Committee could appreciate that such vital duties may often provide more useful and varied employment for patients than activities currently available in the workshops, these are functions which, at other hospitals, are performed by employees. Patients complained that they receive a paltry sum as payment for menial work and also that refusal to do work may well result in sanctions such as withdrawal of privileges or transfer to another ward.

RECOMMENDATION 17

The Committee recommends that the hospital recruit employees to carry out maintenance, food service and housekeeping duties.

RECOMMENDATION 18

The Committee recommends that facilities for occupational therapy and vocational rehabilitation at Oak Ridge be substantially improved. This component must receive high priority when plans to rebuild the facility are being drawn up.

B.4.x. Chapel

The chapel area is located in the basement of the building and is primitive in the extreme. The area doubles as a social and entertainment area and this is where the regular Wednesday evening social takes place.

RECOMMENDATION 19

The Committee recommends that a proper chapel be included in plans for rebuilding Oak Ridge.

B.A.xi. Pharmacy

Three days per week the dispensary nurse checks with the wards in order to determine the supply of medications needed. The nurse is then responsible for ordering the medications from a central pharmacy located at the Regional Division, Penetanguishene Mental Health Centre.

B.A.xii. Ward Nurses' Stations, Treatment Rooms, etc.

Patients' records and clinical charts are stored in the nursing stations at the front end of the ward corridor. Facilities for physically ill patients are primarily available on Ward 06 but there is no actual infirmary at Oak Ridge. Patients who require full hospital nursing care are transferred under secure arrangements to one of the local hospitals.

It was noted that the ward nursing stations and medication rooms are, like some of the other facilities, very cramped and inadequate.

B.A.xiii. Physical Space for other Programs and Services

As remarked earlier, space for interviewing patients in private is sparse. Also, the occupational therapy and vocational rehabilitation services are relegated to the basement of the building.

Adequate facilities for the use of medical consultants are unavailable on the wards although, as noted elsewhere, Ward 01 is refurbishing two patient rooms to create a doctor's consulting room. At present, the dispensary is used for consultations. The dentist has his own office on the front corridor of the building. The Committee regards the facilities for medical, dental and nursing care of patients at Oak Ridge as very inadequate.

RECOMMENDATION 20

The Committee recommends that properly constructed infirmary facilities incorporating consulting and examination rooms be made available at Oak Ridge.

B.5. CHARACTERISTICS OF PATIENTS AT OAK RIDGE

The population of Oak Ridge may be characterized in a number of ways as illustrated by the accompanying Tables 4 through 12. They were derived from data provided by the Research Department, Penetanguishene Mental Health Centre.

B.5.i. Legal Categories

There are very few patients at Oak Ridge who are voluntary or informal (there were none in 1983, two in 1984 and one in 1985). That is, to all intents and purposes, patients at Oak Ridge are held under one of the following legal constraints:

B.5.i.a. Warrants of Remand.

Under several Sections of the Criminal Code a court may remand an accused person to a psychiatric facility for a period of up to thirty to sixty days, depending upon the section. In these circumstances, the court expects a medical-legal report addressing issues relevant to the proceedings. In the event that the accused has not yet been tried for an alleged offence, issues such as "fitness to stand trial" (which relates to possible impairments due to mental disorder at the time of the trial) or "insanity" (relating to the presence of mental disorder at the time of the offence such as to vitiate criminal responsibility) will usually be examined. Other issues, such as treatment recommendations, may also be addressed in such examinations. It should be noted that such remanded patients are resident at Oak Ridge usually only for the duration of the remand which is one or two months. Extensions of such remands are sometimes made when the individual is clearly in need of psychiatric treatment and the hospital is prepared to provide it on a short term basis in order, for example, to bring the person's mental disorder under sufficient control to allow a finding of fitness to stand trial.

B.5.i.b. Warrants of the Lieutenant Governor.

When a court has made a finding of unfitness to stand trial[1] or insanity at the time of the offence[2] the individual is placed on a Warrant of the Lieutenant Governor. In the case of a finding of unfitness, the individual has not yet been tried for his alleged offence. Individuals judged insane have been acquitted of an offence, the effects of mental disorder at the time of their crime precluding conviction according to legal criteria. Such Warrants are indeterminate, that is, they are effective for an indefinite period, potentially for the rest of the person's life, or until the Warrant is completely vacated. As will be described under Section B.12.i. (p.109) of this Report, the Lieutenant Governor may modify the conditions of the Warrant with respect to the facility in which the patient is held, usually upon the advice of the Lieutenant Governor's Board of Review. As can be seen from Table 12, p.35, some patients on Warrants of the Lieutenant Governor may remain at Oak Ridge for very long periods while others may, on relatively rare occasions, be released to less secure environments quite quickly.

B.5.i.c. Involuntary.

Patients may be sent to Oak Ridge from other psychiatric facilites in the Province under the Mental Health Act. Such persons have usually not been currently involved with the criminal justice system and have not been accused, or convicted, of an offence. Such mentally disordered patients have been considered dangerous to themselves or others according to the criteria laid out in the Mental Health Act and their condition has been unmangeable at their parent facility. It is worth noting that such patients may have in fact been very aggressive towards others and justified a charge of assault had not the Mental Health Act been invoked.

A small proportion of patients certified under the Mental Health Act at Oak Ridge have been serving a sentence at a federal or provincial correctional facility. Such admissions are requested usually because the correctional facility is not equipped to manage adequately a mentally ill inmate or have no psychiatric staff. Rather greater numbers of patients are admitted under the Mental Health Act from local jails before their trial. In these cases, correctional psychiatrists have usually regarded the clinical needs of the patients, despite their legal situation, as pressing.

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[1] Section 543 of the Criminal Code of Canada.

[2] Section 16 of the Criminal Code of Canada.

B.5.ii. Numbers of Patients

Over the past few years the total number of patients at Oak Ridge has steadily dropped. As can be seen in the accompanying tables, the population in the hospital on January 1, 1985 was 225. The number of patients in the different legal categories is also shown.

TABLE 4: LEGAL STATUS OF PATIENTS RESIDENT AT OAK RIDGE ON JANUARY 1, 1983-85

	1983	1984	1985
Warrant of Remand	18	14	10
Warrant of Lieutenant Governor	132	108	116
Involuntary (Mental Health Act)	123	104	98
Informal	-	2	1
TOTAL	273	228	225

There are fewer patients in total mostly because there are fewer involuntary patients under the Mental Health Act. The hospital has also admitted fewer patients on Warrant of Remand (143 in 1980 compared with 107 in 1984) though in other respects the number of admissions has not changed appreciably (see Table 5).

TABLE 5: LEGAL STATUS OF PATIENTS ADMITTED TO OAK RIDGE DURING COMPLETE CALENDAR YEARS, 1983 - 1984

(1985 not yet available)

	1983	1984
Warrant of Remand	134	107
Warrant of Lieutenant Governor	38	54
Involuntary	174	175
Voluntary	1	0
TOTAL	347	336

B.5.iii. Immediate Referral Source

From Table 6 it can be seen that the two primary referral sources to Oak Ridge are the courts and provincial psychiatric hospitals. Those referred by the courts, in the three years 1983-1985, comprised 70-75% of all the Warrants of the Lieutenant Governor referred to Oak Ridge; the others in this legal category having been returned from other psychiatric facilities, chiefly the provincial psychiatric hospitals. Referrals from the latter hospitals, excluding the Regional Division of Penetanguishene Mental Health Centre, accounted for approximately 50-65% of all involuntary admissions to Oak Ridge under the Mental Health Act.

The other point to note is that the proportion of referrals from the provincial correctional system, mainly local jails, has increased over the three years depicted in Table 6.

TABLE 6: IMMEDIATE SOURCE OF REFERRAL OF OAK RIDGE PATIENTS RESIDENT ON JANUARY 1, 1983 - 1985

(as a percentage of total patient population: figures to nearest whole number)

SOURCE	1983	1984	1985
Court	48	44	46
Psychiatric Hospital	40	41	34
Provincial Corrections	3	6	10
Regional Division Penetanguishene, MHC	4	5	6
General Hospital	3	1	2
Federal Penitentiary	1	2	1
Retardation Facility	1	1	1
Street	0	0	0

B.5.iv. Primary Diagnosis

It can be seen from Table 7 that the proportion of patients in broad diagnostic categories has changed little over the past few years. The same conclusion is drawn from data on admissions during each calendar year as opposed to the resident population on January 1. However, it is worth noting that in 1976 (data not included in Table 7) when the Social Therapy Program still functioned, 57% of admissions and 47% of the resident population were diagnosed as personality disordered compared with 36% and 42% respectively diagnosed as psychotic. More detailed analysis of data provided by the Research Department, Penetanguishene Mental Health Centre, indicates that the only subtle change has been that a greater number of the Warrants of Remand referrals are now diagnosed as psychotic than hitherto.

TABLE 7: PRIMARY PSYCHIATRIC DIAGNOSIS OF OAK RIDGE PATIENTS RESIDENT ON JANUARY 1, 1983 - 1985

(expressed as percentages to nearest whole number)

	1983	1984	1985
Psychotic[1]	61	61	59
Personality Disorder[2]	27	27	28
Retarded[3]	6	6	8
Others[4]	6	5	5

B.5.v. Most Serious Offence Leading to Admission

From Table 8 it can be seen that, over recent years, there has been a slight increase in the proportion of patients being admitted to Oak Ridge having been charged with murder or attempted murder. Of more note is the fact that the proportion of patients who have committed no offence has dropped. This is chiefly due to the reduction in involuntary admissions under the Mental Health Act (see Section B.5.ii., p.29).

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[1] Psychosis - this category includes the major and severe mental illnesses such as schizophrenia, paranoid and manic-depressive psychoses, which typically affect the patient's perception of reality and may be characterized by hallucinations, delusions, abnormalities of thinking, speech, emotional expression and behaviour. These patients would usually be recognizably "mad" or "crazy" to a lay person.

[2] Personality disorder - these are deeply engrained, inflexible, maladapative patterns of relating, perceiving and thinking of sufficient severity to cause either disturbed functioning or distress. Several sub-categories are described including: anti-social (psychopathic), histrionic (hysterical), paranoid, borderline, schizoid and so on.

[3] Mental Retardation - this term relates to appreciably sub-average general intellectual funtioning existing together with deficits in adaptive behaviour.

[4] Others - this records other diagnostic categories not covered by the foregoing.

TABLE 8: MOST SERIOUS OFFENCES LEADING TO ADMISSION TO OAK RIDGE 1983-85

(expressed as percentages)

	1983	1984	1985
Murder/Attempted Murder	37	41	42
No Offence[1]	35	30	24
Assault	7	8	10
Sex Offence	3	4	6
Property Offence	8	4	6
Armed Robbery	5	5	4
Arson	4	3	2
Missing Information[2]	1	6	5

B.5.vi. Patients who have had Previous Incarceration in Correctional Facilities

The population of Oak Ridge patients who have previously been incarcerated in a correctional facility has remained rather stable at about 30% over recent years (see Table 9 below).

TABLE 9: PREVIOUS HISTORY OF INCARCERATION OF OAK RIDGE PATIENTS 1983-85

(expressed as percentages to nearest whole number)

	1983	1984	1985
No previous incarceration	70	72	68
One incarceration	18	17	12
Two incarcerations	5	6	10
Three or more incarcerations	8	9	10

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[1] These are patients admitted under the Mental Health Act who have not been formally charged but whose behaviour has often been assaultive or otherwise difficult to manage in other hospitals.

[2] These missing data almost certainly do not, according to Research Department staff, refer to serious charges such as murder or attempted murder, but more likely to several minor offences.

B.5.vii. Previous Admissions to Other Psychiatric Hospitals

From Table 10 it can be noted that there has been a very dramatic increase in the number of patients with past psychiatric histories compared to earlier years.

TABLE 10: PREVIOUS ADMISSIONS OF OAK RIDGE PATIENTS TO OTHER PSYCHIATRIC HOSPITALS 1983-85

(expressed as percentages to nearest whole number)

	1983	1984	1985
Previous psychiatric hospitalization	25	80	81

B.5.viii. Previous Admissions to Oak Ridge

The proportion of patients with previous admissions to Oak Ridge has increased by 14 percent over the past three years as can be seen in Table 11. Those on a Warrant of the Lieutenant Governor consist of those released to less secure facilities but who could not be managed there and were returned to Oak Ridge. In the case of the civilly committed patients, there may be a tendency on the part of the referring hospital to return patients to Oak Ridge when it is learned they have been there previously because of, for example, assaultive behaviour.

TABLE 11: PREVIOUS ADMISSION TO OAK RIDGE 1983-85

	1983			1984			1985		
	WLG	Inv.	Tot.*	WLG	Inv.	Tot.*	WLG	Inv.	Tot.*
Previous Oak Ridge Admission	78%	52%	62%	81%	61%	68%	75%	61%	76%

*This total includes Warrants of Remand, Warrants of the Lieutenant Governor, Involuntary and Informal patients.

B.5.ix. Length of Stay at Oak Ridge

Table 12 is of particular assistance in understanding the nature of the long-stay population at Oak Ridge. It can be seen that the mean length of stay for patients held involuntarily under the Mental Health Act is approximately two years. It can also be seen that about one fifth of such involuntary patients will be transferred within a month and almost a half in this legal category have left by the end of six months. However, during 1984 and 1985, approximately one quarter of civilly committed patients had stayed longer than two years. Among those held on Warrants of the Lieutenant Governor, the mean duration of stay of those still resident in the hospital is approximately three years but there is a very considerable variation among this population. It can be seen that only a small proportion leave in less than six months and that about half the patients in this group remain longer than two years.

TABLE 12: LENGTH OF STAY AT OAK RIDGE 1983-85

		1983			1984			1985	
A. No. of Months	WLG	Inv.	Tot.*	WLG	Inv.	Tot.*	WLG	Inv.	Tot.*
Mean	40	18	28	40	24	30	34	26	29
Standard Deviation	51	38	46	51	44	47	50	48	48
B. Percentages by Categories									
one month	7	23	19	5	17	14	5	19	16
2-6 months	9	34	21	15	27	22	17	24	19
7-24 months	29	30	28	23	34	27	34	30	30
more than 2 yrs	55	13	32	57	21	36	44	27	34

*This total includes Warrants of Remand, Warrants of the Lieutenant Governor, Involuntary and Informal patients.

B.6. THE FOUR PATIENT CARE UNITS

B.6.i. Behaviour Therapy Unit (BTU - Wards 07 and 08)

B.6.i.a. Function

The Committee noted that the BTU has a clear statement of purpose. The programs on this unit provide "behavioural treatment for Oak Ridge patients who exhibit dangerous behaviours. In general, the unit is best equipped to treat patients who are not well suited for traditional verbal therapy, who frequently exhibit dangerous problem behaviours within a hospital setting, and who are not too old for intensive behavioural programing".

BTU staff are fully aware that some service or services within the mental health system have to be able to care for very difficult patients. They see it as their job to manage patients which other facilities cannot or will not deal with.

B.6.i.b. Patient Characteristics

Most of the 70 or so patients housed on the BTU are detained under the Mental Health Act, that is, involuntarily, but have not been charged or convicted of a criminal offence, at least insofar as their present admission is concerned. Of the total Unit population, five or six are held under Warrants of the Lieutenant-Governor (WLG). This was reported to be the usual proportion of WLG's and civilly committed patients on Wards 07 and 08. These patients are, in the Committee's view, extremely difficult to treat. Many are retarded. Others are obviously brain injured, and many are profoundly psychotic. Some of the latter can occasionally appear lucid but, apparently, only with effort after which they lapse into their bizarre schizophrenic thought patterns.

The Committee requested the senior staff of the Unit to undertake a case-by-case examination of patient records and provide certain rough data about the population on Wards 07 and 08. They estimated that patients on Ward 07 had spent an approximate average of 40 percent of their lives in institutions of one sort or another, with the least institutionalized having spent 13 percent and the most 80 percent. Estimates for Ward 08 were similar, 47 percent average, range

10 to 100 percent. The Committee was informed that some 42 percent of the total population of the BTU, had had a childhood history of institutionalization or foster care or both. Study of the individual files showed repeated reference to institutions for the mentally retarded such as Smiths Falls or Orillia, and various training schools. The Committee asked the staff to conduct an analysis of all cases on the Unit to form a rough judgment of the proportion of patients who have any reasonably consistent and useful support from their families and were given a figure of 40 percent. It was the impression of senior BTU staff that a greater proportion of the patients admitted to the BTU over recent years are more psychiatrically disturbed than was the case previously.

The bulk of the patients on the BTU are there because of "infractions" against other persons in regional psychiatric hospitals or other Oak Ridge units. As already noted, they represent some of the most difficult management cases to be encountered at Oak Ridge and, therefore, in the Province of Ontario as a whole. They are admitted because the referring hospital is calling on Oak Ridge to solve a problem beyond its power, and because, all other considerations aside, being sent to Oak Ridge may be viewed by sectors of the system as constituting a punishment for badly-behaved patients. It is important once again to recognize that Oak Ridge is but one part of a "system" and it therefore cannot be fully understood without consideration of the whole. Change in Oak Ridge's admission or discharge policies requires examination and subsequent adjustment in the other regional hospitals which are linked with it in the Ontario mental health system. The BTU staff estimated that in only about half the cases is the problem peculiarly patient-centred. In the other half the problems are interactional. The BTU specializes in dealing with serious assaultive problems which are largely patient-centred, repetitive and trans-situational. Other kinds of referrals are seen by staff to be a misuse of the BTU facility though, of course, that is not to say that patients so referred receive no benefit. Although the stated admission criteria address assaultiveness, a few cases are admitted to the Unit, not because they are assaultive but because they would not work or were otherwise uncooperative or non-compliant on another Oak Ridge unit.

B.6.i.c. Unit Program

A detailed written description of the BTU program was made available to the Committee. Most of the patients understood the elements of the token economy system upon which it is based and what they would have to do in order to advance through the program. This system of therapy attempts to modify a patient's behaviour by consistently rewarding desired behaviour ("positive reinforcement"). Conversely, if an undesired behaviour is ignored or punished ("negative reinforcement"), the behaviour is likely to cease ("extinction"). The professional literature on this approach indicates that, at least in theory, the patient needs to be shown what he or she needs to do in order to get through and out of the arrangement. By making the objectives explicit, the patient is expected to decide whether or not to apply effort, and if so, of what kind. The idea is not to take the decision-making power away from the patient, as is often erroneously thought, but to give it to him in the expectation that he will use it to his advantage. Discretionary decision-making on the part of staff should be minimal and constantly under review by both the staff and the patients themselves. Difficulties arise, however, when major decisions affecting the patient's life, for example, those made by the Central Ontario Board of Review or the Lieutenant Governor's Board of Review, depend on considerable discretion being applied by individuals extraneous to the program. Ideally, in a token economy, the patient knows what he has to do to earn the recommendation of the staff; and those staff members, once convinced that the necessary standards have been met, will have appreciable influence over the actions of higher-level decision-makers.

The fact that in this program, the expectations for patient conduct are absolutely explicit makes it reasonably easy to operate. Staff have a clear goal, namely to get patients off Ward 07 and onto Ward 08, and from Ward 08 into some other unit of Oak Ridge or to placement outside the hospital. That, it seems, is the real reward for staff at all levels, even though they know well that a "graduate" will be replaced by some new patient who is equally, and possibly more, difficult to control and treat. Several times in formal and informal meetings with the Committee, staff members appeared to take pride in the fact that some intractable patient had completed the program and gone on to other and better things. It was the Committee's impression that the various staff members had a good grasp of the patients' individual personalities, even those most sadly disabled. In general, then, the tone of this behavioural program transcends the merely mechanical. However, more work is needed in order to develop programs tailored individually for each and every patient. This can only be accomplished through a decrease in the ratio of patients to staff allowing more time to be devoted to therapeutic purposes.

RECOMMENDATION 21

The Committee recommends that behaviour therapy programs be tailored individually for each patient.

RECOMMENDATION 22

The Committee recommends that the patient-staff ratio on the Behaviour Therapy Unit be increased to allow more time to be devoted to therapeutic purposes.

The unit program is carefully monitored by a psychometrist whose task it is to maintain records on each patient. A patient's progress can be readily traced over days or weeks. The numerical system of recording these changes in the patient's clinical record is well understood by all staff. This facilitates the patient's recent conduct being communicated rapidly. With such a system it is difficult for patients to languish week upon week due to lack of staff time for decision-making. The Committee shares the opinion of the Penetanguishene Mental Health Centre's internal review of the BTU[1] that the program managers should try as best they can to increase reliance on positive and not negative reinforcers.

Many of the Committee's detailed visits during 1984 coincided with the summer vacations of recreational and vocational rehabilitation staff. Normally about 30 patients from the BTU participate in this program. However, this avenue was closed at the time and it was soon learned that various patients had taken to breaking windows, often cutting themselves in the process. Some members of staff traced this to inactivity and simple boredom on the part of the patients. It must be stressed that the BTU, when operating normally, does so with the most limited resources. Strong reinforcers (rewards) are few. When vocational-like activities are unavailable, the staff have very little to offer as motivators since the BTU environment and design are not conducive to the creation of substitute programs to fill the gaps. BTU programs would work immeasurably better if the staff could offer more powerful attractions to the patients. The availability of "real work" not just "make work", would be a decided asset. Most prisons offer this. The Committee believes that patients should receive proper recompense for their labours. Sixty cents an hour is a ludicrously small sum. Some patients pointed out that if they were in a penitentiary they could at least be learning a trade. The important point to note is that, as one member of the staff indicated, the reward system must, if it is to develop, become a real economy with control exercised through transactions and not physical force. The uniformity of accommodation and the bleakness of it, coupled with an appalling lack of recreational and vocational opportunities, which have been mentioned elsewhere in this Report, make it extremely difficult to operate a behaviourally-oriented program.

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[1] Professional Advisory Subcommittee Report on Program Review of the Behaviour Therapy Unit, October, 1983.

RECOMMENDATION 23

The Committee recommends that patients in the BTU token-economy programs receive remuneration and reward properly proportionate to effort expended.

Committee members were able to attend an hour long "motivation session". This was carried out by a staff member who used a social learning game with some dozen patients. Considering the level of intellectual and emotional functioning of some of the group, the Committee members could only applaud the effort. The game was well planned and executed. Patients were paired with an eye to their abilities and natural friendships. It was entirely evident that the patients learned something and that they enjoyed, not just the treats handed out at the end, but the activity itself. While the staff member in charge was thus performing, the patients were monitored by two attendants. They were not essentially involved in the motivation session. Their role was limited to allotting points to patients for participation in the exercise. The Committee strongly suggests that attendants be trained to play a more active role in such activities than they were observed to do at the time of the Committee's visits.

RECOMMENDATION 24

The Committee recommends that attendants on the BTU and on other units become more involved with patients, both individually and in groups, and that they be trained for this role.

B.6.i.d. Leadership and Management

On the BTU it was the Committee's observation, based on attending the weekly staff meetings, and from informal interviews with staff, that the senior professional and attendant staff have a firm grasp of the program. They know their assigned patients' present status and condition. Discussions about patients seemed thorough and to-the-point. Decisions were made readily and thoughtfully. Staff members appeared willing to accept the responsibility to explore family concerns with patients, that is, about their management and personal problems. The Committee observed, however, that some members of the attendant staff were not as well versed with the patients' psychiatric histories as they might have been. The fact that patients have been on a Unit for a long period, and therefore well known to the staff, should not mean that such considerations are omitted.

RECOMMENDATION 25

The Committee recommends that all attendant staff on the BTU and on other units, become fully aware of the clinical histories of the patients in their care.

Control is a central issue in such behavioural programs as that on the BTU. It is possible for authority to reside in one of three domains: 1) with the patients; 2) with the attendant staff; and 3) the senior professional staff. Ideally, over time, the control should be vested increasingly in the patients, the aim being to assist them to achieve self-determination. Although this may happen to some extent in many cases, the disabilities of many of this group of patients places some limits on what might otherwise be possible. This results, as is common in programs of this kind, in a power struggle between professional and attendant staff. The professional staff members want to see the program work because of its intrinsic characteristics. This means having exact specifications of behaviours to be reinforced and extinguished in each case. In actual practice it is difficult to provide an exhaustive list of what is and what is not to be done. Attendant staff, it would appear, desire moment-to-moment discretion in decision making. Professional staff recognize that if the attendant staff have autonomous, unlimited discretionary power, there is a risk that decisions may become arbitrary, which is the absolute opposite of the requirements of such a program. There is, for example, an understandable concern on the part of the professional staff that, unchecked, reinforcement can be delivered by attendants on the basis of personal liking rather than through specified patient performance.

From the point of view of the attendants, however, it is not necessarily easy to accept that control should reside not in their own hands but in the program. They wish to take pride in the accomplishment of the tasks through their own personal efforts, not something that is as vague as a program, and one created largely by others at that. The behavioural management task of the attendants is a difficult one. This was brought out by the members of the attendant staff but it was also stressed by the senior professional staff. One problem is that the BTU is asked to function as a behaviourally-oriented project in an institution geared along other lines. The BTU staff, as with the entire attendant staff of Oak Ridge, have been imbued with the idea that gaining of control of the patients is a fundamental objective. With the BTU program, the effort is to have the staff relinquish control, in the service of the contingency program, and to accept that patients cannot learn if not allowed to make mistakes. A balance thus has to be struck between control and treatment. Within limits, somewhat disapproved behaviours have to be allowed to occur. To run programs like this requires some measure of "nerve" on the part of the leader, since it often places them at variance with the attendant staff and indeed with higher administration.

One other feature about the program monitoring deserves comment: the Director believes in conducting regular weekly rounds. He indicated that it is necessary to do so in order to ensure that he personally sees each patient at least every week. In the Committee's view, the Director is correct in allowing patients to approach him in this way and make appointments to see him privately. The Committee observed that senior professional and attendant staff are in frequent attendance on the wards and that not much escapes their notice.

The appointment of a non-medically trained mental health professional as a unit director is a departure from tradition at Oak Ridge. As will be clear from discussion about other units at Oak Ridge and elsewhere, it may also be unavoidable in the relative absence of trained medical staff. The Oak Ridge system as a whole was observed to have some difficulty adjusting to the recent delegation of administrative and clinical directorship to a non-physician. The Committee is, however, firmly convinced that the present arrangement is working out well and should be supported.

RECOMMENDATION 26

The Committee recommends that the Behaviour Therapy Unit while it continues to exist at Oak Ridge, be directed, as now, by a specialist in behavioural management.

B.6.i.e. Staffing Resources

The staff complement on the BTU is more satisfactory than in the past when there was, for example, only one attendant on duty on each ward at night. There is, in addition to the Unit Director, a full-time psychologist who can assume the directing role at times when the Director has to be absent. There is also a psychometrist, a social worker, a nurse, and an Area Supervisor. Recently, an R.N.-level Ward Supervisor was appointed on Ward 07. This member of staff had had many years experience as an attendant before completing his nursing training. There is available to the BTU the regular complement of attendant staff though, not infrequently, members are dispatched to help manage crises elsewhere in the hospital. When this happens, patients are often of necessity "locked up". The ratio of staff-to-patients should be increased with the important and strict stipulation that such increase to the staff complement be directed at improving therapy and behavioural monitoring rather than security (see Recommendation 22, p.39).

A good proportion of attendant time goes to the meeting of sheer physical needs of the patients - showering them, feeding them, shaving them, etc. Not infrequently attendants have to cope with patients who throw food or feces. The work involves a good deal of physical contact with these difficult patients. Yet the very arduousness of the job creates a certain esprit de corps and the Committee members were told that most of the attendant staff on the BTU would prefer working there than elsewhere in the hospital.

B.8.i.f. Use of Medication

The BTU is directed by a non-physician who relies on consultations with a medically-qualified colleague regarding medication of patients. At the time of the Committee's early visits, this service was provided by a staff psychiatrist. Subsequently, these duties were taken over by a physician who, though not a qualified psychiatrist, has had psychiatric training. He provided 15 hours a week for the task of dealing with medications and certifications on the BTU. Committee members attended two meetings, one under each system, and the arrangements seemed to work satisfactorily. However, it must be appreciated that many patients on Wards 07 and 08 are there precisely because psychotropic medications have lacked dramatic effectiveness in their cases. The Committee found no obvious cases of over-medication on the BTU and the senior professional staff indicated that they adhered to a policy of using the minimum-effective dosages of medications though they fully appreciated that drugs were necessary in some cases.

B.8.i.g. Use of Confinement

Being confined means being locked in a safe room. It is a procedure employed for those exhibiting seriously aggressive and dangerous behaviour to self or others. This patient management technique is one frequently employed on the BTU. On Ward 07 for example, a patient may be confined for a period of five days for: 1) fighting or attempting to fight with staff or members of the public; 2) possession of a dangerous weapon; or 3) a serious escape attempt. Three days confinement may be ordered for: 1) being an aggressor in an assault or fight between patients; and 2) major destruction of hospital property. On Ward 08, the limit to confinement is held at three days. Such a period of seclusion may be given for: 1) assaulting or attempting to assault staff members or other patients; 2) hoarding medication; 3) serious destruction of hospital property. Patients on this ward can be transferred to Ward 07 in order to receive a five day confinement. In the one month period from September 11 to October 11, 1984, twelve patients on Ward 07 received three days confinement and another twelve received five days confinement. On Ward 08, twelve patients received three days. The major reason provided for imposition of confinements was attempting to fight with co-patients and staff.

The members of the Committee understand the behavioural principles upon which the BTU program is based and also the treatment and management difficulties imposed by Wards 07 and 08 patients. As well, the Committee notes that the Unit does have a policy on seclusion and it is in writing. However, seclusion for such long periods is extremely hard to justify. It is questionable whether the lengthy periods of seclusion are more effective as behavioural modifiers than shorter periods.[1] It is also difficult to rationalize why a patient receives five days in seclusion for assaulting a staff person and three days for assaulting a fellow patient. The internal report on the BTU[2] suggested that patients in confinement be reviewed after 24 hours with the possibility that extension be permitted. It is noted that the Unit Director rejected this recommendation. The Committee's discussion of this issue with senior staff raised the point that such an alternative arrangement, were it to be adopted, could result in patients spending even longer periods in confinement for serious infractions than at present. Time extensions could be given daily for six or more consecutive days. The Committee is strongly of the view that, on the basis of what is fair, reasonable and humane, a 24-hour period of "time out" in seclusion be employed as the absolute outer limit.

Further detention beyond 24 hours might be possible only under extraordinary circumstances and only if supported by the highest authority in the hospital, that is, the Administrator, in consultation with the Medical Director or his deputy. Although the Committee well understands that, given the nature of the BTU philosophy and principles, certain exceptions may have to be made (e.g. to maintain use of "time out" procedures in cases where a plan has been developed and approved for individual cases in advance), the patient in seclusion ought to be placed under continuous nursing observation. It is also thought that actual use of seclusions within the BTU (and other Units) should be reviewed at least monthly by the hospital's Administrator and Medical Director.

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[1] See Tardiff, K. (ed). The Psychiatric Uses of Seclusion and Restraint, American Psychiatric Press, 1984; Lion, J.R. & Reid, W.H., Assaults within Psychiatric Facilities, Grune & Stratton, 1983.

[2] Professional Advisory Subcommittee Report on Program Review of Behaviour Therapy Unit, October, 1983.

RECOMMENDATION 27

The Committee recommends a 24-hour time limit for seclusion be instituted in the Behaviour Therapy Unit.

RECOMMENDATION 28

The Committee recommends that detention in seclusion beyond 24 hours within the BTU be permitted only on the authority of the Administrator in consultation with the Medical Director or his deputy.

RECOMMENDATION 29

The Committee recommends that all uses of seclusion throughout Oak Ridge be reviewed at least monthly by the Administrator and Medical Director.

B.6.i.h. Ethical and Legal Issues

Patients sign no consent to participate in the behavioural program of the BTU. Those few on this Unit who are competent to refuse the program should, in the Committee's view, be permitted to do so. Only in this way can the patients' rights be respected. However, it is only by demonstating improved behaviour that transfer from Oak Ridge can be achieved; thus there is a natural incentive to participate. On the other hand, it seemed to the Committee members that the bulk of the patients on the BTU probably lack competence to give informed consent due to their emotional and intellectual limitations. The rights of patients in this category must therefore be acknowledged and treatment given only in accordance with the provisions of the Mental Health Act[1]. The Committee is of the view that the Patient Advocate could play a helpful role on the BTU. At the time of its site visits, the Committee was informed that the Patients Advocate's Office was infrequently involved with BTU patients. However, it must be acknowledged that referrals to the Advocate must arise from patients themselves.

RECOMMENDATION 30

The Committee recommends that the Patient Advocate's Office be more regularly involved with patients on the BTU around issues of consent to treatment.

B.6.i.i. Length of Stay

A census taken on 1st January, 1985, showed that there were 45 involuntary patients who had been at Oak Ridge, primarily on the BTU, a mean of 46 months. There were 10 WLG patients, slightly more than at the time of the Committee's site visists. Four of those had been found unfit to stand trial and they had been present for a mean of 125 months (i.e. over 10 years). The remaining six, who had been found not guilty by reason of insanity, had been in Oak Ridge, mainly in the BTU, for a mean of 67 months (i.e. about five and a half years). No unfit WLG patients were discharged from the Unit during 1984. Three not-guilty-by-reason-of-insanity patients were discharged and these had been in the facility for a mean of 65 months. The 23 involuntary patients discharged from the BTU had averaged 15 months in the program.

B.6.i.j. Other Issues

With most of the residents of Wards 07 and 08 being civilly committed, it is possible to question whether at least some of these particular problem patients could not in fact be efficiently cared for and treated in the provincial hospitals and mental retardation facilities which referred them in the first place. The Committee was in no doubt that some patients are inappropriately referred and could be handled at their parent hospitals. Yet the Committee doubts that the average provincial hospital could or should cope with certain other patients. To do the job requires a special purpose-built facility and well trained staff. Most of the Committee take the view that patients who are civilly committed and face no criminal charges should be held in separate facilities from those who have been involved with the law[1]. However, while there may be value in creating more medium secure units within the existing hospitals (see Recommendations 2 and 3), it must be realized that some of these patients, at least for a time, require a greater degree of security than a medium-security unit can provide. The population of wards 07 and 08 could be and should be reduced in the short term if necessary through firm time limits, fully negotiated in advance with referring hospitals. The Committee is further of the view that civilly committed patients under the Mental Health Act who require a higher level of security than a medium secure unit, should be managed in a purpose-built unit located separately from the rest of the Oak Ridge population. Such a unit could be established within the Regional Division, Penetanguishene Mental Health Centre, and could take advantage of the expertise which presently resides within the BTU.

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[1] Mental Health Act, R.S.O. 1980, c.262, s.35.

RECOMMENDATION 31

The Committee recommends that violent civilly committed patients referred from provincial psychiatric hospitals should be managed outside Oak Ridge at a purpose-built facility within the Regional Division, Penetanguishene Mental Health Centre.

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[1] It must be noted here that Dr. John Gunn urged against this approach. In his view it tends to encourage a prison-like ethos.

RECOMMENDATION 32

The Committee recommends that if civilly committed patients have to continue to be accommodated within Oak Ridge over the short term, their lengths of stay be limited through careful negotiation in advance of admission.

B.6.ii. The Extended Treatment Unit (ETU - Wards 04 and 06)

B.6.ii.a. Function

The purpose of the ETU is clearly stated in its Program Description (undated): "To provide vocational training, extended treatment and preparation for discharge for patients who are not management problems at Oak Ridge." Admission and discharge criteria are also clearly laid out as are the various program components. However, extended treatment services, although rather comprehensive in the program description, are offered on a limited basis, as evidenced by statistics already given in the description of rehabilitation and vocational resources. See Section B.4.ix. (p.22).

The ETU functions as a holding unit for those patients who have progressed through programs of the other units at Oak Ridge including those few who are referred from the Behaviour Therapy Unit. For some it is the last stage, preparatory for discharge, while for others it serves as a chronic care ward. A few additional patients, namely those convalescing from medical problems or requiring close access to the dispensary, or both, are also housed on Ward 06.

The ETU most commonly discharges patients to other regional mental health centres and is seen as coming as close to a medium secure unit as exists at Oak Ridge. There is a backlog of patients on the ETU who are ready for discharge according to clinical criteria and who, perhaps, would benefit from services available in other parts of the provincial mental health system. Several patients interviewed by the Committee indicated that they had been through the various programs at Oak Ridge, were now merely "putting in time", and were quite bored and frustrated. Such patients expressed the idea that they were being "warehoused", while awaiting a recommendation for transfer to a medium secure unit by the Lieutenant Governor's Board of Review.

Patients indicated that they viewed the therapy on the ETU as that which derives from the work to which they are assigned. Because many of the patients had previously participated in various therapeutic endeavours while on other units, they showed little interest in the range of programs offered on the ETU such as sex education and social skills. Many of them reported that the social skills program was of a very basic kind and could not reasonably be expected to help them with the types of problems they anticipated they would face, (e.g. such as how to rent an apartment, how to look for a job, how to cope with the stigma of previously having been a patient at Oak Ridge, and the like). As reported by staff, the social skills program deals with such matters as how to relate to persons of the opposite sex and how to deport oneself in various social situations. A number of patients were not from the metropolitan areas and felt that the content of the social skills programs was of little assistance to them in dealing with the local situation they would likely return to.

It was observed by patients that information about the hospitals to which they were about to be transferred was minimal. On the whole the patients indicated that there were insufficient individualized programs geared to providing specific information in order to help each patient to reintegrate into a new environment.

RECOMMENDATION 33

The Committee recommends that programs for patients on the ETU be individualized and redesigned to make them more generally relevant to life in other hospitals and the community.

Despite the limitations of the resources as observed on the ETU, there are sincere efforts being made. However zealous these may be, as a whole the ETU is falling somewhat short of achieving its stated purpose.

B.6.ii.b. Patient Characteristics

The functions of the ETU are complicated by the fact that it houses many of the long-term WLG patients who have a primary diagnosis of psychopathy or some other personality disorder. Many of them have been in the system for more than five years and long since ceased to display, if they ever did, symptoms of other mental illnesses such as schizophrenia or affective disorder. Many of the patients on this unit are quite intelligent and articulate, and are also seen by some of the staff as instigators in attempts to force improved conditions for patients in the hospital. A number of the patients in this group are viewed by the hospital as being appropriate for discharge to a medium-security unit from a clinical point of view. However, this opinion is not being supported by the recommendations of the Lieutenant Governor's Board of Review.

A second group of patients on the ETU consists of persons appreciably mentally more impaired, some of whom are involuntarily detained under the Mental Health Act. These patients are relatively less verbal, require higher doses of medication and have greater difficulties in interacting with other people. Though there are not many patients in this category, the number has increased in recent times according to staff. Similarly, staff members reported that there has been some increase in the number of patients who are new to the Lieutenant Governor's Warrant system and still clearly display evidence of having a fairly immediate potential for danger to others. Another issue becoming a problem on this Unit is that of patients refusing medication. At the time of the Committee's site visit, two or three of these patients had recently deteriorated mentally and had needed to be transferred to another unit at Oak Ridge.

Most of the patients on the ETU were reported by staff to be on Warrants of the Lieutenant Governor with a few having involuntary status. Patients reported that they were there because they had rotated through two or three other programs at Oak Ridge. Others returned to Oak Ridge having failed to accommodate to the medium-security units or other parts of the mental health system. Those admitted to the ETU from other units in Oak Ridge would be judged to have advanced to a sufficiently successful level of self-awareness, social deportment and self-control and would be considered able to live and work in a less structured, more privileged, open ward system. By and large, patients on Ward 04 were more articulate and self determined than those on Ward 06. For example, on Ward 04 there was a high patient involvement in ward management and an accompanying expectation to be so. The Committee observed that this is taken seriously by both staff and patients. On Ward 06 the staff assumes greater responsibility for organizing and managing patient affairs. Ward 06 appears to have a higher proportion of intellectually impaired patients than Ward 04. Again, the proportion of patients on Ward 06 who are on medications was reported by staff to be higher than on Ward 04.

The staff reported that patients in the ETU are by no means homogeneous beyond the fact that, generally, they do not constitute management problems. Personality disorders, chronic psychotics, the intellectually impaired, persons who will be discharged and those for whom future placement outside Oak Ridge may be quite distant, make up the population of approximately 65 patients. Some would appear to have considerable intellectual potential and to have a good capacity for educational and vocational rehabilitation, even if they do not have the requisite control over antisocial and violent tendencies. Other patients could not aspire beyond simple routine tasks. A good number are in the Unit in order to determine whether or not, in the more open, permissive milieu, they can actually contain themselves and function in a non-aggressive, socially-responsible manner. Some, as indicated earlier, are accommodated on ETU because they do not require the stringent control methods of the BTU yet are still viewed as potentially dangerous. Others are in the ETU because they do not require the intensive treatment programs directed at the more disturbed or psychotic patients. It becomes apparent with this combination that it might be somewhat challenging to design programs that meet the variety of theraputic problems presented by these patients.

Many of the patients interviewed, especially those on Ward 04, are inclined to believe that they no longer need to be at Oak Ridge, stating that they have been through all the programs which are offered and there is nothing more for them. They see themselves as putting in time awaiting a "positive decision" by the Lieutenant Governor's Board of Review. Most of the WLG patients clearly understood why they were detained and recognized it was the role of the Lieutenant Governor's Board of Review to determine when they are ready to leave the hospital. Although WLG patients expressed considerable frustration at their continued detention, most were at least aware of which body was responsible for it. However, this was not always as clear to the intellectually handicapped patients on the ETU. Some of the more recent admissions also were unclear about their legal status. Of these, some have reason to be confused in light of the fact that several are "dual status" patients. One patient is not only on a WLG but is, also, a "dangerous offender" under Part XXI of the Criminal Code. The point here is that such a prisoner/patient must, in order to obtain release, deal with both the parole authorities and the Lieutenant Governor's Board of Review.

Most of the offences committed or allegedly committed by patients on the ETU were reported by staff to be of a very serious kind, usually of personal violence, sometimes with sexual overtones. With respect to social difficulties, some of the newer, more clearly disturbed patients have a rather low level of education and social skills. A number of these patients could probably benefit from not only a more comprehensive social skills program but also from continuing education to help them proceed beyond grade 8 or 9. There are essentially no educational programs for patients. Some patients mentioned they were taking correspondence courses but there is only one teacher at Oak Ridge and very few other educational resources available. This is in sharp contrast to several facilities visited by some members of the Committee. It is the Committee's view that facilities like Oak Ridge benefit from strong educational programs and that professional teachers are well placed to serve therapeutic as well as educational ends. (see Recommendation 16, p.22.)

A number of ETU patients chiefly those diagnosed as suffering from antisocial and other personality disorders, are facing difficulty in that the hospital is taking the position that it is unable to treat them further. The senior hospital staff views these patients as having benefited as much as they can from the programs offered. Yet it is not in the hospital's power to release them or to transfer them to another facility. Some of the patients were aware that this is the prevalent view of their situation and, consequently, they felt somewhat forgotten in the current system. They indicated they have difficulty coping with the bitterness they feel at having made progress but being unable to transfer to a medium secure unit in order to pursue further therapy and rehabilitation. Men whose crimes were sex-related often made the point that it was difficult for them, and for the staff, to evaluate their progress until they were regularly interacting with women in a more natural social situation. Several mentioned that they were pleased to have a female nurse and female attendant on the Unit.

RECOMMENDATION 34

The Committee recommends that the policy of hiring female attendant (nursing) staff for the ETU and elsewhere at Oak Ridge be extended.

Although the Committee has decided not to make a formal recommendation on the point, it notes here that the possibility of mixing male and female patients at Oak Ridge might be considered in the future. However, the present system whereby female patients requiring special security are accommodated on the medium secure unit at St. Thomas Psychiatric Hospital, appears to work satisfactorily.

B.6.ii.c. Programs

According to the documents provided to the Committee by the unit staff, the Extended Treatment Unit offers a wide range of programs. The specialized group programs are described in considerable detail, and the ward management system is likewise clearly presented, as are the vocational and hospital services components. The best part of the program in reality is the work detail. All but a very few patients on the ETU work. Less clear is the degree of consistency with which the stated special group projects are provided. At the time of the Committee's visits, the only projects reported to be available were a social skills group and a sex-offender program. The status of the "problem solving" group was uncertain. The "discharge planning group" was in abeyance temporarily while the Unit social worker was away.

It would be unreasonable to expect, given the limited numbers of professional staff available to conduct small groups, and the inadequate physical arrangements, that the entire range of special programs referred to in the program description could be offered simultaneously. This is compounded by the fact that staffing for these groups in addition to professional members, calls for one or two attendant staff who are not consistently available. To some extent the ETU is meeting its stated goals but the resources allotted, both in space and trained personnel, clearly prohibit the Unit from realizing more fully the programs as they have been envisaged.

RECOMMENDATION 35

The Committee recommends that the staff-to-patient ratio on the ETU be increased in order that established programs can actually be offered with sufficient frequency and intensity.

The program involves encouraging work activities during the day combined with encouraging patient-patient interaction during the off hours. This is accomplished in part by a committee system on the Ward. These features were outlined in the Unit's Annual Report and in the written description of Ward 04 functions. During the patient-management meetings the lack of patient-staff interaction was observed by the Committee to be a frequent cause for comment by the patients. Many of the patients reported that the only therapy they obtained was in their conversations with other patients, particularly the WLG's, many of whom were viewed as "well" by other patients. If the objective is to determine whether the patients can relate to each other in an institutional setting, it appears in fact to be fairly successful on this ward. The patients achieve some understanding of how small groups or committees can function. This knowledge might be helpful later in a work situation.

Much of the ward-related work experience is at a menial level. Other than the social training involved and the completing of assigned tasks, it is difficult to envisage to what extent patients learn skills helpful to them for employment on the street. The incentive wages paid are minimal at best. This method of remuneration is not intended to help the patient save money to assist him upon release. The range of pay is so low that it could not be viewed as an incentive for most patients. Many patients complained that they feel exploited in being required to work in the hospital while resident on the ETU. As noted in Section B.4.ix. (p.22), the Committee is of the view that much of this maintenance work should be undertaken by hospital employees (Recommendation 17, p.25). However, where it is appropriate for patients to receive payment for work completed, it should be at community rates.

RECOMMENDATION 36

The Committee recommends that patients on the ETU and elsewhere at Oak Ridge be paid appropriately for work completed.

One effect which the ETU program does achieve is that it deliberately creates situations in which some freedom is given to the patients. They are allowed to make decisions about such matters as when they want to shower and participate in outdoor yard activity. On Ward 04 patients are given a range of choices and can elect whether or not they want to participate in various activities, and if so, at what time. However, if they do not go to the yard, for example, they are locked in their rooms or, if they choose not to watch TV, then they have an obligation to "interact" with other patients. They may visit each others' rooms for the purpose of socializing. This is difficult for some patients who are not completely well mentally and who have just come from very structured programs elsewhere at Oak Ridge. The Committee noted that there have been some referrals directly from the BTU to ETU. The transition from the highly structured BTU to the relatively "free" regimen on the ETU is really quite dramatic, and would require a patient to make a considerable adjustment.

The range of privileges allowed on Ward 04 falls short in terms of preparing patients to live in either a medium secure environment or in a general population of a regional hospital. Although it does provide, in some cases, opportunity for patients to interact with one another and to participate in decision-making in regards to their day-to-day activities, there can be little doubt that it does not afford the kinds of opportunities required by patients at this stage of their confinement experience. In other similiar institutions which the Committee visited, patients at a corresponding stage were, for example, free to cook their own meals and live in conditions more akin to life outside hospital.

RECOMMENDATION 37

The Committee recommends that selected patients on the ETU be allowed substantially greater opportunities than at present to learn the essentials of independent living.

Ward 04 appears highly organized for the purpose of patient control. The central committee on this Unit consists of five patients, the Ward Supervisor and the Ward Nurse. It clarifies policies and coordinates ward activity. Staff influence who is selected to sit on this committee including patients who volunteer. The entire ward population votes, in some cases to ratify the selection of patients to the committee. In reality, the Ward Supervisor has the final say. The work of the committee appears to be to clarify questions, make requests, and bring up various ward issues. No reference was made to individual patients or their behaviour, etc., at the meeting attended by the Committee members. The ward meeting, which requires the attendance of all patients and staff, was held following the central committee meeting. The central committee report was presented and followed by reports of various ward committees, for example, sports, security, and so on.

Ward 06 is somewhat less structured in terms of ward meetings and overt central committee functions than Ward 04. However, on this ward, a highly efficient system is in place which relies on patients reporting on other patients to staff. The central committee meets with staff but not regularly or frequently. Patients who do not comply in attending ward meetings are transferred from the ward. Ward 06 patients were, or seem to be, less self-determined and less verbal than those on Ward 04.

B.6.ii.d. Leadership and Management

The Committee members observed that the Unit Director of the ETU exercises little management control over the Unit. Other personnel, the Area Supervisor and Ward 04 and 06 Supervisors, make the decisions and enforce them on the ETU with the Director's endorsement. The Director may be advised of the outcomes. Both of the Ward Supervisors exercise an appropriate degree of supervision over the attendant staff.

On Ward 04 there exist different philosophies of patient care and control and some of the older, traditional, custodially-minded attendant staff reported that the Unit and Ward supervisors were too permissive in "giving into" the "rights" of the patients. Some of the other attendant staff supported the new directions being taken on 04. These tensions were clearly evident in the discussions held at times of the Committee's visits.

The registered nurse, assigned to this Unit, was by all reports, accepted by staff and patients. The scope of professional nursing duties included a wide range of tasks primarily dealing with the general health care of patients, coupled with coordinating medical appointments and related clinical matters. The nurse attended and contributed to discussion of patients at the patient-management meetings. The nurse expressed interest and a desire to be accessible to patients and to have a more substantial counselling role.

Several departments are charged with ETU programing. They come together regularly in order to address patient management and broader administrative issues. Vocational service staff were present and their opinions seemingly valued at two patient management meetings attended by the Committee members. Nevertheless, it was unclear to what extent the program is integrated, re-emphasizing the absence of clear unit direction.

RECOMMENDATION 38

The Committee recommends that a non-medical professional staff member be appointed to strengthen the direction of the ETU in terms of the development, coordination, and evaluation of programs.

B.6.ii.e. Staffing Resources

Staffing on the ETU is an issue of concern according to all levels of personnel interviewed. Professional staff are needed in most disciplines. Services are extremely stretched and in some areas the incumbents are being required to extend their professional services to the limit possible. It may be a reason, for instance, why the Vocational Rehabilitation and Activity Centre programs were closed when certain staff were away and why some of the recreational programs are unable to run at full tilt.

B.6.ii.f. Use of Medication

The Director of the ETU sees each patient at the management meetings about once every two weeks. The registered nurses are responsible for calling attention to medication orders for patients when they are due at the monthly psychiatric medication review.

Few of the patients interviewed on Ward 04 reported being on medication. It is indeed difficult to estimate the extent of possible over-medication without very detailed review of charts and patients individually. There were, however, some patients on the ETU wards who appeared to be excessively somnolent. Refusal to comply with medication is considered to be a contravention of the criteria for continued residence on the ETU. The patients' behaviour could thus be labelled as uncooperative and provide the grounds for transfer to another ward.

Psychotropic medication is prescribed by the Unit Director who is a licensed physician with some psychiatric training. However, there is no qualified psychiatrist appointed to the ETU. The patients' medications are reviewed during the patient management meetings. Although the Director did not articulate the type of medication prescribed for selected patients at the meeting attended by Committee members, it was pointed out that medication issues are discussed freely with the patient. Compromises are apparently made in some situations in order to encourage patients to take some of the medication rather than to risk having them refuse all of it. However, the Committee questioned the therapeutic efficacy of this approach.

As with some of the other units at Oak Ridge, the Committee strongly urges that psychiatric consultation services be provided for the ETU. A method whereby this could be accomplished is described in Section B.8.i. (p.86).

RECOMMENDATION 39

The Committee recommends that psychiatric consultation, particularly but not exclusively around medication issues, be provided for ETU patients as soon as possible.

B.6.ii.g. The Use of Confinement

Patients complained that, when staff are urgently needed elsewhere in the building, they are locked up in their rooms. When such "lock-ups" occur, staff shortages are usually cited as the reason. Other forms of seclusion imposed on Wards 04 and 06 include the locking of patients in rooms when they do not wish to participate in recreation, outdoor exercise, TV and other organized social activities. These "lock-ups" can continue for two hours or more according to the duration of the activity. Again, these "lock-ups" are reported to be the result of insufficient numbers of attendant staff to monitor ward security. In line with Recommendation 35 (p.54), the Committee considers it essential that staff complement be brought up to a level which makes such "lock-ups" unnecessary on the ETU.

B.6.ii.h. Ethical and Legal Issues

Patients on Ward 04 consistently denied physical maltreatment at the time of the Committee's visits but were prepared to state that some physical abuse continued to be meted out on Ward 06. Reference was made by patients to choking and banging patients against metal doors and other such rough treatment. It was difficult for the Committee to learn about the treatment of intellectually handicapped patients on Ward 06. However, psychological abuses were not only reported but witnessed by a Committee member. Accusations were made to the Committee that certain staff "play games" with patients by taunting them, bothering their visitors, making demeaning remarks and generally fostering an untherapeutic relationship. The issue of patient abuse is discussed more fully in Section B.10.i. (p.99).

RECOMMENDATION 40

The Committee recommends that ETU attendant staff be made more clearly aware of the adverse effects of psychological mistreatment of patients. Unit and Ward administrators must be prepared to discipline staff in these circumstances.

B.6.ii.i. Length of Stay

According to a census taken on 1st January, 1985, there were eight involuntary patients on the ETU who had been resident at Oak Ridge for a mean of 31 months. There were three persons detained on WLG's as unfit to stand trial who had been resident a mean of 14 months. Forty five ETU patients on WLGs as not-guilty-by-reason-of-insanity (NGRI) had been in the facility for an average of 39 months. Twenty five NGRI warrant cases were discharged from the ETU during 1984. On average they had been there 39 months. Twenty one civilly committed patients were discharged from the ETU during that period and these had a mean length of stay of 17 months. These figures should be interpreted with caution since mean lengths of stay disguise the actual variability in time spent at Oak Ridge. Some patients have been on the ETU for many years and have, in fact, little hope of release or transfer. Others have been there only a short while pending transfer to medium secure units in accord with recommendations made by the Lieutenant Governor's Board of Review.

B.6.ii.j. Other Issues

There is considerable testing going on, particularly on Ward 04, where the more assertive patients are questioning many actions as they relate to their "rights". Patients complained of their dissatisfaction with the outcome of formal complaints and appeals. Some staff were inclined to confuse patient rights with administrative directives and other hospital policy. The Committee noted a pervasive fear of being sued on the part of staff. There is clearly a need for staff to be educated in this general area, a task well suited to the Legal-Clinical Liaison Officer. See Recommendation 72 (p.93).

B.6.iii. Forensic Assessment and Treatment Unit (FATU - Wards 01 and 02)

B.6.iii.a. Function

The two wards of the Forensic Unit serve quite separate functions. The patients on Ward 01 have been sent on Warrant of Remand from the courts of Ontario for psychiatric assessment. Reports are provided which address forensic issues such as fitness to stand trial, possible application of Section 16 of the Criminal Code (the insanity defence), bail suitability, dangerousness, and possible dispositional recommendations. This ward also provides short term assistance for those likely to be found unfit to stand trial. Ward 01 accommodates the Social Adaptation Treatment program which was developed, according to written statements provided to the Committee by the hospital, for patients with severe personality disorders who have not been able to benefit from other therapy programs at Oak Ridge. Ward 02 provides longer term treatment in a therapeutic community program.

B.6.iii.b. Patient Characteristcs

In the year during which the Committee's review took place (1984) there were 120 admissions to the Forensic Unit[1]. One hundred and five (85%) were on Warrants of Remand from the courts. About half of these patients were diagnosed as psychotic with the rest as having personality disorders. The written admission criteria for the Forensic Unit specify that patients must have been charged with or convicted of a personal injury offence, have a documented need for maximum security or have an escalating pattern of violent behaviour. The data confirm that all admissions had committed some criminal offence, the majority involving personal violence such as murder or attempted murder, assault, armed robbery or sexual offences. Most had been in correctional facilities, and psychiatric facilities including Oak Ridge at least once in the past. At the time of the Committee's visits, Ward 01 housed 15 patients on Warrants of Remand, three patients in the Social Adaptation Treatment Program and five "patient-teachers" who have been at Oak Ridge for some time and were sufficiently mentally intact to carry out functions described later in this section. The census at the time of the visits was thus 23 patients out of a possible 36.

The Unit Director's secretary provided specific data for the Committee on the sources of referral of patients on Warrant of Remand. These are summarized in Table 13. From this it is clear that most of the remands are coming from Metropolitan Toronto or areas closely adjacent. It is worth noting here that, in 1984, approximately 25% of the remands had been examined previously at either METFORS (Metropolitan Toronto Forensic Service) or the Forensic Service of the Clarke Institute of Psychiatry in Toronto. Oak Ridge staff suggested that such cases were remanded again in this way because the Toronto facilities were unable to contain the patients adequately. However, experienced forensic psychiatrists from outside the Toronto system noted that Crown Attorneys often prefer to have offenders sent to Oak Ridge for psychiatric examination as the heavy emphasis on security at the facility conveniently accords with the prosecution's understandable preoccupation with the protection of society.

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[1] Data provided by Reseach Department, Penetanguishene Mental Health Centre.

TABLE 13: REMAND ADMISSIONS TO THE FORENSIC UNIT, OAK RIDGE DIVISION, MENTAL HEALTH CENTRE, PENETANGUISHENE, 1984

AREA[1]	PERCENT
LONDON	
HAMILTON	11.0
TORONTO[2]	5.5
KINGSTON	55.0
OTTAWA	1.5
NORTH BAY	12.5
NORTHERN ONTARIO	5.5
	10.0
	100.0

RECOMMENDATION 41

The Committee recommends that forensic assessment facilities providing a higher level of security than is presently available be developed closer to the bulk of the patient population in Metropolitan Toronto.

Cross-reference is made here to Recommendation 1 of this Report which advocates that a central coordinating policy and department should be developed to allocate patients referred by the courts on Warrants of Remand to an appropriate assessment facility.

The characteristics of patients accommodated on Ward 02 of the Forensic Unit are very different from those on Ward 01. There were 32 patients on Ward 02 at the time of the Committee's visits, slightly more than are considered by staff to be the optimal number but less than the bed availability for 37 patients. These patients are a mixture of those on Warrants of the Lieutenant Governor and those civilly committed under the Mental Health Act. The latter includes patients who had originally entered Oak Ridge on Warrant of Remand and had been certified under the Mental Health Act in order to effect treatment.

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[1] These areas are taken from the "Report on Psychiatric Services to the Criminal Justice System in Ontario" prepared for the Legal Task Force of the Committee on Mental Health Services of the Ontario Council of Health by B.T. Butler and M.F. Dunbar, 1978.

[2] Even if Toronto is restricted to the immediate metropolitan area, it still accounts for 29 percent of remands.

B.6.iii.c. Programs

In keeping with its function, programs on Ward 01 are directed mainly towards the process of assessment. The exception is the Social Adaptation Treatment Program which is described by the hospital as designed for patients who have demonstrated severe personality disorders, who have failed to respond adequately to programs elsewhere at Oak Ridge and who continue to be difficult to manage. Although designated by the term "program", in fact it is simply a highly structured system of strict control. For example, the patient is allowed to communicate only with staff, "patient-teachers" and other patients in the program. Other rules and regulations contained in written materials provided to the patients were reviewed by the Committee members who noted that whatever the therapeutic intention of the program, there is no escaping the conclusion that it is restrictive to the point of harshness. The ultimate sanction is "total loss of privileges". As these privileges are stated to include: radios, cassette players, cigarettes and tobacco, reading material, footwear, canteen visits, toiletries, games, yard exercise, visits, meals, television, telephone, jewellery, stationery supplies and educational opportunities, the Committee presumed that all of these could be withdrawn. Although surprisingly no complaints specifically about this potential degree of punitiveness was heard from the patients, the Committee was very concerned that basic necessities or simple comforts potentially could be removed so easily in the name of therapy.

RECOMMENDATION 42

The Committee recommends that no "program" should exist at Oak Ridge which potentially permits excessive deprivation of basic necessities of civilized life.

Upon admission to Ward 01, patients on Warrant of Remand are expected to complete a battery of written psychological tests if their psychiatric condition permits. The Committee noted that this battery is of a fairly traditional type used at other facilities. However, it was questioned whether it is necessary or desirable in most patients admitted, especially those who are suffering from severe and acute mental disorders.

RECOMMENDATCON 43

The Committee recommends that the necessity for routine psychological assessment on Ward 01 be re-examined.

A further question raised in this connection derives from reports that "patient-teachers" score some of the psychological test results.

RECOMMENDATION 44

The Committee recommends that psychological tests be administered and scored only by staff qualified to do so (see also Recommendation 81, p.102).

On Ward 01, patients on Warrant of Remand are not allowed to speak to each other but they may speak to staff and "patient-teachers". Several explanations for this rule were put forward by attendant and professional staff: to minimize the risk of plots by patients to escape or take hostages; the need to protect the patient if he discloses information, for example a sexual charge, which may subsequently put him at risk should he be incarcerated; the need to protect staff who could, as the law currently stands, be subpoenaed by a prosecutor to testify about confessions or other statements a patient may have made during the course of the examination. Not only does the existence of this "silence rule", in conjunction with other conditions at Oak Ridge, render the facility legally vulnerable (see Appendix C, p.149), but the difficulties to which it is purported to be a solution are not restricted to Oak Ridge. Any facility which conducts psychiatric examinations of remanded prisoners faces the same problems and none, to the Committee's knowledge, restricts the basic right to spontaneous discourse.

RECOMMENDATION 45

The Committee recommends that the "silence rule" on Ward 01 be rescinded.

Medical staff reported that on occasions they may employ the disinhibiting agents, sodium amytal and alcohol as as part of their assessment procedures. Although these techniques may have a legitimate place in the forensic psychiatrist's armamentarium, the Committee was concerned that such methods, if used without adequate safeguards, are contentious.

RECOMMENDATION 46

The Committee recommends that Oak Ridge develop a written policy with guidelines for the use of specialized psychiatric assessment procedures.

On completion of testing, patients enter groups whose function is to discuss a series of mimeographed articles on interpersonal behaviour and the provisions of the Mental Health Act. Patients are observed throughout the early days of admission and reports are made by both staff and "patient-teachers". Psychiatric assessment and medical examination are conducted as soon as practical. As on the Admission Unit, extensive use is made of "case historians" who document the patients' biography in great detail. Although the Committee was impressed with the quality and accuracy of these case histories, they are only a partial substitute for experienced psychiatric assessment.

The Committee noted with concern that some patients may be confined indefinitely to their rooms if they are considered "too disruptive or unable to function in groups, etc and that "the onus (is) on the patient" to justify liberation[1]. The Committee refers here to Recommendations 27, 28 and 29 (p.46). These apply also to the Forensic Unit.

Psychotic patients who experience difficulty in functioning in more structured assessment groups may enter a "pilot" program whose rules are relatively relaxed. Patients are encouraged to talk about their problems and emotions with "patient-teachers" who make a report on their progress to the attendant staff. The stated goals of the program[1] are to learn the Unit rules and regulations, display appropriate demeanor on the ward and attempt to resolve the personal problems which led to admission. Patients who progress satisfactorily through this "pilot" program may be transferred to other programs for further therapy, either on the Forensic Unit or elsewhere at Oak Ridge, or returned to Court.

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[1] Annual Report, Forensic Unit, 1983.

Ward 02 programs, quite unlike those on Ward 01, are directed towards treatment rather than assessment. Specifically, the programs constitute a "therapeutic community" with heavy reliance upon a system of committees run by patients. Thus, the programs are the most substantial remnant of the Social Therapy Program which flourished at Oak Ridge during the 1960's and early 1970's and which was briefly described in the Introduction to this Report.

There is a plethora of committees on Ward 02 and patients are required to be on at least one of the six available. For example, there is a Ward Committee, whose responsibility is to ensure that the ward is kept clean and tidy and that equipment and supplies are maintained. Members of this committee have the specific task of daily scrutinizing all rooms and conducting two major ward inspections a week. There is also a Security Committee whose function is, as the term implies, to aid in the management of such crises as interpersonal violence or suicide attempts. Such patients may be physically restrained and placed in devices such as "cuffs"[1] by the committee members to prevent further violence. Staff are reported usually to approve the actions of the committee in these circumstances. Perhaps most important of all in this system, is the Staff-Patient Liaison Committee. This is a group of three patients whose role is to assure cooperation between attendants, professional staff and patients. It plays a central role in the appointment of other committees and monitoring and disseminating their decisions among the wider patient body. Members of the Staff-Patient Liaison Committee are especially privileged in that they are free to attend all other patient committees and it is one of their central functions to be totally aware of events in the ward. Other committees include those with functions of clarifying ward issues, treatment management and application of sanctions. Thus, the whole program revolves around a complex interaction of various small groups of patients.

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[1] These are used to tie two patients together where one is likely to act out, perhaps violently (see page 71, Section B.6.iii.g.)

The Committee is familiar with the theory behind the therapeutic community model. As noted earlier in this report, Oak Ridge's Social Therapy Program formerly achieved international recognition in this very area. At the present time, however, the program appears to lack the drive and sense of direction which formerly characterized it. The Committee members were concerned, on the basis of observations and patient reports, that staff, especially trained professional staff, spend little time on a day-to-day basis monitoring the detailed functioning of this program. As well, there seems an imbalance between the weight of the committee structure and the actual opportunities available to patients for more normal social, educational and vocational interactions. In part this reflects statements made already in this Report concerning the lack of amenities of all kinds at Oak Ridge. Staff interviewed by the Committee frequently mentioned this lack of activities and many wished as much as the patients that more useful activities could be made available. Also, attendant staff indicated that the Therapeutic Community Program functioned more satisfactorily at a time when the patient population consisted primarily of those with personality disorders. There may well be a place for a therapeutic community ward, suitably reorganized and constructed at Oak Ridge, as this appears to be the treatment modality of choice for such patients[1]. However, as the numbers of chronic schizophrenic patients has increased, the Committee questioned whether the progam is as therapeutically useful as it once was[2].

RECOMMENDATION 47

The Committee recommends that the suitability of the therapeutic community program for chronic schizophrenic patients on Ward 02 at Oak Ridge be re-evaluated.

In fact, there exists a "pilot" program on Ward 02 specifically designed for psychotic patients who, while in remission, are not yet able to participate in the rest of the ward programs. As is usual throughout Oak Ridge with such programs, the function is very basic and aimed at achieving social conformity by means of a system of rewarding and withholding privileges. As previously, the Committee reiterates that such systems should not deprive patients of basic necessities or comforts (See Recommendation 42, p.64). Also, patients should be carefully supervised by trained staff and this, at the time of the Committee's visits, seemed beyond the Unit's resources.

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[1] See Gunn, J., Robertson, G., Dell, S. and Way, C. Psychiatric Aspects of Imprisonment, Academic Press, 1978.

[2] See Paul, G.L. & Lentz, R.T. Psycho-Social Treatment of Chronic Mental Patients: Harvard University Press, 1977.

RECOMMENDATION 48

The Committee recommends that, if the therapeutic community program on Ward 02 is retained, it should be supervised by a professional staff member, trained and experienced in this modality.

B.6.iii.d. Leadership and Management

The Unit Director of the Forensic Unit is the only full-time psychiatrist at Oak Ridge with the recognized Canadian specialty qualification. An experienced and similarly qualified psychiatrist assists on a part time basis. It was evident to the Committee that the Unit Director exercises strong and respected leadership despite the fact that he is frequently away from the hospital providing court testimony on patients he has assessed. In view of this, not surprisingly, some patients on Ward 02 complained that they had limited access to him.

B.6.iii.e. Staffing Resources

In addition to the availability of a full-time, trained psychiatrist as Unit Director, the Forensic Unit is in a favourable position compared with other Oak Ridge units in having gained a substantial increase in the number of other professional staff in recent times. These included a psychologist about to complete his Ph.D., an M.A.-level Psychometrist, a social worker with a Master's degree (who was formerly an attendant) and two "case historians". The latter role was created as a solution to the problem of the chronic shortage of trained professional staff. The Committee has earlier in this section noted the advantages and disadvantages of this system.

However, frequent mention was made of the need to recruit another forensic psychiatrist on Ward O1 to assist the Unit Director. Furthermore, the Committee has noted the desirability of a program director experienced in therapeutic community techniques on Ward 02 (see Recommendation 48, p.69).

RECOMMENDATION 49

The Committee recommends that, for as long as remand assessments are conducted at Oak Ridge, additional specialized forensic psychiatric expertise be made available to the Forensic Unit.

B.6.iii.f. Use of Medication

Those patients in the Social Adaptation Treatment Program and the six patient-teachers are either stabilized on medication or not receiving it at all. At the time of the Committee's site visits, about 60% of the remanded patients were suffering from obvious major mental illnesses. These patients would be considered by most psychiatrists as in need of medication, at least as an initial part of treatment. The matter of whether a patient on Warrant of Remand should be medicated to bring his mental illness under control, in order to be found fit to stand trial, continues to be a contentious issue[1]. Difficulties arise if a patient refuses the recommended treatment. In a sample of cases reviewed by the Committee, medication selection and dosage was appropriate and capably monitored on the Forensic Unit. This is attributable simply to the fact that the Unit Director is a fully qualified and experienced psychiatrist.

Hitherto, Ward 02 housed a large number of personality disordered patients. At the time of the Committee's review, many were diagnosed as chronic schizophrenics. However, they had usually been stabilized on medication and consequently needed less frequent monitoring by a psychiatrist than the more acutely disturbed patients. Nevertheless, the registered nurses reviewed the patient's medication monthly.

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[1] See Roesch, R., & Golding, S.L.: Competency to Stand Trial, Urbana: University of Illinois Press, 1980.

B.6.iii.g. Use of Confinement

The Committee has made suggestions elsewhere in this Report for the adoption of a written set of guidelines for the use of seclusion and restraint. These will of necessity, be tailored to the individual programs within the different units and the Forensic Unit is no exception.

A special form of restraint is employed on Ward 02. This is the practice referred to on page 67, of "cuffing" two patients together in a situation where one of them is liable to act out, perhaps with violence, and the other is expected to contain and help restrain him. The procedure originated in the heyday of the Social Therapy Program. However, patients themselves told Committee members that they resented being expected to assume this responsibility. The Committee was unable to see how the procedure could be regarded as therapeutic in these circumstances, and can only assume that it is retained simply because of shortage of staff to monitor patients sufficiently disturbed to require continuous observation.

RECOMMENDATION 50

The Committee recommends that the practice of cuffing patients on Ward 02 be discontinued and that alternative procedures for close or continuous nursing observation be instituted.

B.6.iii.h. Ethical and Legal Issues

Some matters of ethical and legal significance on the Forensic Unit have already been discussed or alluded to. These include the "silence rule" and the excessive use of seclusion and withdrawal of privileges which may constitute deprivation of basic human necessities and reasonable comforts.

Another ethical and legal problem brought to the Committee's attention is the fact that on Ward 01, patient rooms may be illuminated for extended periods even during hours intended for sleep, ostensibly to facilitate continuous observation by attendant staff. In its site visits to the Regional Treatment Centre, Kingston Penitentiary, the Committee noted the use, in similar circumstances, of closed-circuit television cameras which function at low light intensities. Such technological developments seem to be far more satisfactory and less intrusive than the practice at Oak Ridge.

RECOMMENDATION 51

The Committee recommends that the system for monitoring acutely disturbed patients on the Forensic Unit be reappraised with a view to acquiring more modern methods of surveillance.

Some patients complained that water supplies to their rooms on Ward 01 had been restricted and that this necessitated calling an attendant to provide water. Staff, however, indicated that this measure is sometimes necessary to prevent disturbed patients from using materials such as toilet paper and the like to block the toilets and cause flooding.

RECOMMENDATION 52

The Committee recommends that the practice of interrupting water supplies to patient rooms on Ward 01 and on any other unit where this may be done, be used only in exceptional circumstances where justification can be demonstrated. These reasons should be documented clearly in the patient's clinical record.

At the time of the Committee's visit, staff reported that remanded patients were not allowed out to the yard for exercise because of security considerations and staff shortages. This restriction is, in the Committee's view, inhumane and unsupportable. Furthermore, in conjunction with other deprivations and restrictions, it makes the hospital potentially vulnerable to legal challenge (see Appendix C, p.149).

RECOMMENDATION 53

The Committee recommends that patients on remand be provided outdoor exercise at least commensurate with that permitted to an individual serving a prison sentence. One hour per day is suggested as the absolute minimum.

Finally, mention must be made of the characteristics of the Social Adaptation Treatment Program. This matter was reviewed by a consultant forensic psychiatrist appointed by the Ministry of Health following complaints by two patients in this program in 1982. Despite the consultant's misgivings, this program has continued to exist albeit with rather less harsh restrictions. A central issue raised by the consultant was the fact that the patients placed in the program had not given specific consent to participate and had simply been told that the program had been developed with their problems in mind. The Committee endorses the viewpoint that no therapy program for mentally competent patients should be imposed without the patient's written consent. However, this approach, though current in contemporary psychiatric-legal thinking, differs appreciably from the traditional treatment ethos at Oak Ridge which was once designated as "coercive milieu therapy". The point which the Committee makes here is not that there can be no pressure upon patients to undergo treatment, as this is difficult to avoid if release is contingent, at least to some extent, upon therapeutic response, but when a specific treatment modality or program is offered, the patient must know what is intended, what alternatives there are, and what consequences will follow if the program or treatment is rejected. The same suggestion is made with respect to the Therapeutic Community Program on Ward 02.

RECOMMENDATION 54

The Committee recommends that mentally competent patients throughout Oak Ridge must give written consent to participate in specific programs or to receive specific treatments.

B.6.iii.i. Length of Stay

On Ward 01, remanded patient's length of stay is usually determined by the legally-specified time limit of 30-60 days. On average, patients on the Forensic Unit who are held on Warrants of the Lieutentant Governor (chiefly on Ward 02) have remained for approximately 16 months in the case of insanity acquittees and, on average, for four months in the case of those found unfit to stand trial. Involuntary patients under the Mental Health Act have remained on this Unit for an average of seven months.

B.6.iv. Admission Unit (AU - Wards 03 and 05)

B.6.iv.a. Function

The Admission Unit receives all new admissions to Oak Ridge with the exception of patients referred on Warrants of Remand who are accommodated on the Forensic Unit (Ward 01). Once admitted, patients are assessed and treated until they have either recovered from their mental illness or their behaviour has become sufficiently manageable to permit discharge or return to the referring facility or to another Oak Ridge unit for further treatment.

It is stated in various documents provided by the hospital to the Committee that, regardless of legal status, only patients identified as "dangerous" qualify for admission. However, this characteristic is not clearly defined. Thus, there needs to be developed a mental health system-wide definition, together with supporting policies, in regard to "dangerousness", and also specific criteria for admission to Oak Ridge. The Committee sees this function as suitable for inclusion among the responsibilities of the bureau mentioned in Recommendation 1 (p.10).

RECOMMENDATION 55

The Committee recommends that a mental health system-wide definition of "dangerousness" be developed, together with supporting policies and specific criteria for admission to Oak Ridge.

B.5.iv.b. Patient Characteristics

During the year of the Committee's review (1984) 215 patients were admitted to this Unit. One hundred and sixty six (77%) were involuntary patients under the Mental Health Act. Approximately one third of these patients originated from provincial correctional facilities, chiefly local jails or detention centres, where they were awaiting trial[1]. The hospital also provided information about the sources of the other mental health referrals which are summarized in Table 14.

TABLE 14: SOURCES OF MENTAL HEALTH REFERRAL TO ADMISSION UNIT, OAK RIDGE DIVISION[2]

REFERRAL SOURCE	%
Psychiatric Facilities in Metro Toronto (Queen Street Mental Health Centre, Clarke Institute and others)	36
Medium Security Units (M.S.U.'s; Brockville, St. Thomas, North Bay)	7
Provincial Psychiatric Hospital where M.S.U.'s Proposed (Whitby, Kingston)	22
Penetanguishene Mental Health Centre, Regional Division (including Bayfield Unit)	17
Other Psychiatric Facilities in Ontario	18
	100

Therefore, with the exception of the correctional referrals, the bulk of the admissions come from provincial psychiatric hospitals including the Regional Division, Penetanguishene Mental Health Centre, and general hospital psychiatric units. Especially noteworthy is the fact that over one-third derived from psychiatric facilities in Metropolitan Toronto, almost all from Queen Street Mental Health Centre and the Clarke Institute of Psychiatry. Also striking is the large proportion who have been transferred to the Admission Unit at Oak Ridge from the Regional Division, Penetanguishene Mental Health Centre, in particular from the Bayfield Unit which is a specialized, locked unit for psychiatrically disordered, intellectually handicapped adults.

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[1] Data provided by Research Department, Penetanguishene Mental Health Centre.

[2] From data provided by Penetanguishene Mental Health Centre.

Interestingly, provincial psychiatric hospitals which already have functioning medium-security units (Brockville, North Bay and St. Thomas) made relatively few referrals. On the other hand, those two hospitals where such units are proposed (Whitby and Kingston) referred appreciably more.

Recent data from the Research Department further indicate that more than half of the admissions to the Admission Unit had committed no criminal offence. Approximately 60% were diagnosed as psychotic and most had in fact been patients at Oak Ridge in the past, suggesting that the "revolving door" operates with respect to this group of patients.

The Committee draws the conclusion from these data that provision of adequate alternative facilities for acutely psychiatrically disturbed, civilly-committed patients, could substantially reduce admissions to Oak Ridge. Many such patients may well not require its very high level of physical security. Further, there is clearly an urgent need to provide such alternative facilities in the Metropolitan Toronto area.

RECOMMENDATION 56

The Committee recommends that more adequate facilities for the acute management of violent psychiatrically disturbed patients be developed at provincial psychiatric hospitals. These are needed with special urgency in Metropolitan Toronto.

B.6.iv.c. Programs

Ward 05 acts as an assessment ward for new admissions to Oak Ridge. Here patients are under close observation for a few days before entering either a "pilot" group or "motivation assessment" group. "Patient-teachers", that is, patients who have been at Oak Ridge for some time and are mentally well enough to perform this task, direct these groups. These appear to serve as a forum for discussion of various mimeographed papers, some defining ward rules and regulations or the provisions of the Mental Health Act, and others dealing with various aspects of interpersonal behaviour. During the initial few weeks following admission, a psychiatric interview is performed. In fact, what is recorded is the findings of the mental status examination. The more usual psychiatric history which is documented in most psychiatric hospitals is, at Oak Ridge, undertaken by "case historians". The latter were trained for this task by the Unit Director who is a physician but who does not possess a recognized Canadian qualification in psychiatry. In addition, psychological testing is usually performed. This consists of a battery of standard psychometric tests such as the Minnesota Multi-phasic Personality Inventory and an intelligence test. Observations by both attendant staff and the "patient-teachers" are recorded. Information is gathered from other institutions where the patient has been treated together with other relevant sources of data.

Committee members reviewed all the clinical charts relating to patients on Ward 05 during one of their visits. The quality of recording was extremely variable. Some would be at a standard acceptable in most adequate psychiatric facilities in Ontario. Others fell far short of this standard (see also Section B.9.iv, p.97). In particular, it was noted that clear description of abnormal mental phenomena was often lacking, even where it might be expected, and there was a prominent tendency to focus on undesirable behaviours, typically in pejorative tones.

RECOMMENDATION 57

The Committee recommends that the role of the "patient-teachers" on the Admission Unit at Oak Ridge be very carefully supervised by trained, experienced professional staff (see Recommendation 81, p.102.)

RECOMMENDATION 58

The Committee recommends that recording of clinical observations of patients on the Admission Unit document more clearly the presence and progress of psychiatric symptomatology and not simply undesirable behaviour.

The Committee observed that the assessment procedure on the Admission Unit follows a rather traditional course, with unique local variations, in which pertinent information is collected and a psychiatric diagnosis reached as soon as practical. What is striking is that the referring facilities, which usually have adequate numbers of trained staff, have sent their patients for specialized care to a Unit where such trained staff are noticeably lacking.

As soon as a psychiatric diagnosis has been established, treatment is applied, almost invariably along pharmacological lines. It is worth noting at this point that the staff reported that electroconvulsive therapy is not frequently used on the Admission Unit. The hospital provided statistics on its use of this procedure but these did not discriminate between cases at the Regional Division and at Oak Ridge. However, recently and subsequent to the Committee's visits, information has come to light through the Patient Advocate's office, suggesting irregularities in the application of the treatment at Oak Ridge in some specific instances. In the light of contemporary concerns[1] over this treatment modality, the guidelines for its use at Oak Ridge should be re-evaluated. In particular, psychiatric consultation is desirable before resorting to this treatment.

RECOMMENDATION 59

The Committee recommends that clear policy and guidelines, including the use of adequate psychiatric consultation, be developed for the use of electroconvulsive therapy at Oak Ridge.

Once the patient's acute disturbance is under some control, usually within a period of 3 to 4 weeks, he is transferred to Ward 03 where there may be opportunity for further treatment. In the Penetanguishene Mental Health Centre internal review of the Admission Unit[1], it was pointed out that the Admission Unit devotes almost all its efforts to ameliorating florid psychiatric symptoms and deals very little with the other problems with which these patients are afflicted such as social incompetency and anti-social tendencies. At this point, it is worth noting that senior and informed psychiatrists from other provincial psychiatric hospitals made the observation that many civilly-committed patients whom they refer to Oak Ridge's Admission Unit present a dual problem: acute mental illness requiring primarily pharmacological treatment and anti-social behaviour or other serious management problems which tend to require rather longer periods of specialized supervision. The Committee was, however, sympathetic to the fact there are some 60 acutely disturbed psychiatric patients under the care of only one physician. It is difficult to see how it would be possible to deal with other than urgent treatment considerations. Whereas the Committee is of the view that greater involvement of psychiatric expertise is required on this Unit, the development of suitable programs addressing social skills, anti-social attitudes and behaviour, and so on, requires further attention of suitably trained and experienced professionals from other disciplines (see Recommendation 60, below).

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[1] Electro-Convulsive Therapy Review Committee, Report to Ministry of Health pending.

RECOMMENDATION 60

The Committee recommends that the psychiatric component of the Admission Unit be strengthened through the addition of qualified psychiatric consultants.

B.6.iv.d. Leadership & Management

Both patients and attendant staff reported that the leadership on the Admission Unit and derived primarily from competent and resourceful Area and Ward Supervisors. This is fortunate in the sense that as matters stand the Unit Director must of necessity, be involved in direct assessment and treatment of patients using psychotropic medication. Thus, clinical management of acute psychotic disturbances assumes priority over the functions of unit direction and related administrative and program development issues.

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[1] Professional Advisory Sub-Committee Report on Program Review of the Admission Unit, Oak Ridge, November 1984.

RECOMMENDATION 61

The Committee recommends that the Admission Unit be reorganized and that it be administered by a professional qualified in program development.

B.6.iv.e. Staffing Resources

From the foregoing account it is obvious that staffing resources on the Admission Unit are woefully inadequate to the task of managing this group of patients, who are referred, often from better endowed facilities, because of difficulties in treatment and management. The Unit Director, who has had psychiatric training but does not possess the Canadian qualification in psychiatry, is providing psychiatric services virtually single-handed. Use of "case historians" has reduced the load on the Unit Director but is, in the Committee's view, no substitute for adequate levels of psychiatric expertise.

Also, as the patient population on the Admission Unit is typically acutely psychiatrically disturbed, it makes sense to have a larger number of nursing staff who have adequate training and experience with such clinical problems.

One further professional group whose absence was mentioned by staff and patients alike was that of a trained social worker.

RECOMMENDATION 62

The Committee recommends that greater numbers of psychiatrically trained and experienced nurses and a qualified social worker be added to the staff complement of the Admission Unit.

B.6.iv.f. Use of Medication

As already noted, psychotropic medication forms the mainstay of treatment on the Admission Unit. The Committee did not note any evidence of obvious mismanagement of medication, given that many of these patients certainly require pharmacological treatment, at least initially. However, the concern is reiterated that patients referred to Oak Ridge need psychiatric and nursing attention of the highest order. It is thus important to increase the availability of psychiatric expertise and the numbers of psychiatrically trained nurses on this Unit as recommended earlier (see Recommendations 60 and 62, p.80).

B.6.iv.g. Use of Confinement

Confinement involves transfer to either a safe room, which is stripped of potentially harmful materials, or seclusion within the patient's own room. These steps can be invoked arbitrarily by attendant staff. "Patient-teachers" may also recommend seclusion to the Unit Supervisor. In turn, the Supervisor's actions must be justified to the physician. Staff reported that patients are not denied other amenities during the confinement but are simply segregated from others.

The staff indicated that they had a large capacity for tolerating deviant behaviour and that they feel confident in knowing "when somebody is ready to come out of seclusion". However, the Committee recommends that written criteria should be developed for the use of seclusion on this Unit as elsewhere at Oak Ridge (see Recommendations 27, 28 and 29, p.46). The reasons for secluding a patient should be fully documented by those involved in making this decision. Also, the Committee suggests that patients placed in seclusion should, on this Unit at any rate, be concurrently on continuous nursing observation. The Unit Director should be involved in confirming the approval for seclusion, and, if the individual appears to require seclusion for more than 24 hours, the Hospital Administrator, in consultation with the Medical Director should review the situation.

RECOMMENDATION 63

The Committee recommends that a written seclusion policy be developed by the Admissions Unit and that this be in accord with that used on other units at Oak Ridge.

B.6.iv.h. Ethical and Legal Issues

On the Admission Unit, the main ethical issue specific to the program is that patients who have not been charged with a criminal offence are mixed with others who have. This concern was brought to the attention of the Committee by the Patients' Advocate, the Office of the Ontario Ombudsman and in some instances the patients' legal counsel. It was also one of the issues discussed by the earlier report on Oak Ridge[1]. The Committee believes that adequate facilities should be developed for these patients within regional psychiatric hospitals. See Recommendation 56 (p.76) and further discussion in Section C (p.149).

Also of concern to the Committee was the degree of coercion that appeared to be applied to the patients on the Admission Unit with respect to taking medication. Notwithstanding the difficult management problems which these patients present, the issue of consent is central and the law explicit. Where a patient is competent to do so, he may accept or refuse a recommended treatment. When the patient's competence is questioned, the physician recommending the treatment may take steps to obtain surrogate consent from the patient's relatives. If this route is not available, the Mental Health Act makes provision for this to be possible under carefully safeguarded circumstances[2].

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[1] Task Force Report on the Oak Ridge Division, Mental Health Centre, Penetanguishene, 1973.

[2] See Mental Health Act, R.S.O. 1980, c262, s.35, and R.R.O. 1980, Reg. 609, Section 4, and Schedules 1-4.

RECOMMENDATION 64

The Committee recommends that staff on the Admission Unit become better informed of the legal provisions surrounding the issues of consent to treatment. The Clinical-Legal Liaison Officer has an educational role in this regard (see Recommendation 72, p.93).

B.6.iv.i. Length of Stay

The staff of the Admission Unit were not consistent among themselves in their reports of the length of stay for patients on this Unit. Data provided by the Research Department, Penetanguishene Mental Health Centre, indicated that involuntary patients had remained on this Unit on average for six months. Those held under a Warrant of the Lieutenant Governor had remained 33 months on average in the case of those found "not guilty by reason of insanity", and an average of six months in the case of those found unfit to stand trial.

B.7. GENERAL MEDICAL AND HEALTH CARE OF PATIENTS

Registered nurses were in attendance on most units during the Committee's visits. They deal with some of the patients' minor medical problems. On some wards, the female nurses are not encouraged to go down the long corridors unescorted and therefore do not become as fully integrated into the ward activities as is desirable. Although the Committee was given various reasons for this, it was apparent that some of the male attendant staff, particularly those with a strong machismo orientation, encouraged the perception of these patients as especially dangerous towards females. There is among some of the attendant staff a mistrust of the registered nurses as of other professionals at Oak Ridge.

At the time of the Committee's visits, there were no specific nursing stations for the nurses to do their work with patients. The dispensary acted as the central nursing station. If the layout of the wards were not as they are, that is a long corridor with rooms on both sides, more normal interaction between nurses and patients would probably be possible.

Medical care for the Oak Ridge patients is delivered by contract physicians on a part-time basis. An on-call system is in place for the remainder of the 24-hour period holidays and weekends. Physicians from both the Regional Mental Health Centre and Oak Ridge provide the on-call general medical care. Local hospitals serve as the active treatment institutions. The nurses commented that at times it was difficult to secure physician services at Oak Ridge for the emergency duties in evenings and at nights.

B.7.i. Access to Physicians and Nurses by Patients

There was a mixed response from patients in terms of obtaining appointments with physicians and with their satisfaction with medical care. Some reported that the registered nurses screened them to such an extent that it was difficult to see a physician. However, from the examples provided by patients, access to medical care was felt by the Committee to be as available to them as it is in the community. Generally the registered nurses assigned to the wards were seen by patients as being accessible to them. This factor alone did not suit some patients in terms of getting the action they wanted for their medical problems. On the other hand, attendants stated that by having registered nurses more readily available, patients now complain more about health problems and made more requests for medical care. Figures were not available to determine whether requests to see the physician had increased over the period of time nurses had been reassigned from a central dispensary to specific wards. However, the nurses did not share the same opinion as the attendant staff in regard to increased patients' requests.

The medical and nursing care available on most wards was adequate. Each ward had assigned to it one registered nurse. On some occasions the Committee noted that the nurses assigned to a given ward were also assigned elsewhere in the facility. Examples include spending part of their day with patients undergoing electroconvulsive therapy and assisting with the clinics being conducted in the dispensary.

Future plans for general medical and health care include the addition of clinical examination rooms on the second-floor wards. Thus, instead of patients being escorted to the dispensary, physicians assigned to specific wards would regularly attend a group of patients. As it is now, patients are escorted to the dispensary unless the patient's behaviour or condition precludes moving him from the ward.

The nurses appeared to be a caring group who interact freely with the patients when the opportunities arise. The increased contact between the registered nursing staff and the patients is noted to be one the benefits of assigning nurses to the wards.

However, the role of these registered nurses at Oak Ridge is restricted to the care of the general physical health problems of the patients. The absence of registered nurses to perform psychiatric nursing duties falls appreciably short of the resources available at other provincial psychiatric hospitals.

RECOMMENDATION 65

The Committee recommends that the number of registered nurses at Oak Ridge performing psychiatric nursing duties, as opposed to general medical and health care, be increased to levels comparable with other psychiatric hospitals in Ontario.

B.7.ii. Supervision of Medical and Nursing Services at Oak Ridge

Contract physicians at Oak Ridge were reported to be directly responsible to the Medical Director at the Regional Mental Health Centre. The Head Nurse, who is responsible for some aspects of the management of the medical services, reports to the Director of Nursing at the Regional Mental Health Centre and through the Chief Attendant at Oak Ridge. Concerns about the medical care arrangments and services provided and other aspects of the general medical care are reported to the Chief Attendant (R.N.) at Oak Ridge who in turn is directly responsible to the Director of Nursing, Regional Mental Health Centre.

RECOMMENDATION 66

The Committee recommends that the Medical Director, Penetanguishene Mental Health Centre, review the provision of general medical services at Oak Ridge.

B.7.iii. Dental Services

Dental care is provided by a dentist appointed to the Regional Mental Health Centre. His services are shared between the Regional Mental Health Centre and Oak Ridge. The dentist attends Oak Ridge patients for only one-half day a week. Although all staff and patients who were interviewed considered the quality of dental care to be adequate, its availability is not consistent or regular at Oak Ridge. The only time when patients go to the dentist for regular check ups is if they themselves request them, and the Committee was told that even on these occasions there can be a substantial waiting time to see him. Another complaint regarding dental services was that patients would be advised that there will be a call back arranged by the dentist within some specified period of time but that these arrangements were rarely made. From what the Committee observed, there are a great many patients who could benefit from a regular program of corrective dentistry and dental hygiene, and probably also from dental health education.

RECOMMENDATION 67

The Committee recommends that the provision of dental services to patients at Oak Ridge be increased.

RECOMMENDATION 68

The Committee recommends that a dental hygienist be added to the Oak Ridge staff complement and that such a person have a role in dental care education.

B.8 STAFF RESOURCES

B.8.i. Medicine

The Medical Director of the Penetanguishene Mental Health Centre, which includes the Oak Ridge Division, is a trained psychiatrist with a specialist certificate in psychiatry from the Royal College of Physicians and Surgeons of

Canada. His overall administrative responsibilities preclude his active participation in the day-to-day clinical management of many patients in the hospital. However, he does provide consultations when requested and formerly conducted a therapy group for the difficult psychopathic patients in the Social Adaptation Treatment Program at Oak Ridge.

Although some of the other Oak Ridge medical staff possess various levels of psychiatric training and experience, there is only one full-time physician at Oak Ridge with the recognized Canadian Specialist Certificate in Psychiatry. Although recent acquisition of general practitioners has helped with the workload, frequent mention was made to the Committee of the dire need for more trained psychiatric staff. In 1984, the representatives of the Canadian Council on Hospital Accreditation in their report on the Penetanguishene Mental Health Centre as a whole, noted: "Despite the vigorous recruiting efforts which include the stop gap hiring of locums, the hospital continues to have a serious shortage of physicians and especially a serious shortage of fully qualified psychiatrists. It is not felt that one full time certified psychiatrist at Oak Ridge reaches minimum standards, considering he must spend about 40 days a year at court"[1]. The Committee fully endorses this comment. It should be noted that the hospital's inability to attract qualified psychiatrists and other medical staff is striking and in sharp contrast to its adherence to a traditional "medical model" of administration. The Committee proposes that the administrative structure of Oak Ridge be "demedicalized" by replacing medical unit directors with clinical, but non-medical, directors as was adopted with the Behaviour Therapy Unit.

RECOMMENDATION 69

The Committee recommends that the administrative structure at Oak Ridge be reorganized and increased reliance be placed on suitably qualified non-medical unit directors.

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[1] Recommendation 16. Canadian Council on Hospital Accreditation Report on Penetenguishene Mental Health Centre, 1984.

The scarce medical manpower should be redeployed where most needed and should be retained in a consulting capacity and coordinated by a Chief Psychiatrist. In the Committee's view, it is most unlikely that, at least in the short term, recruitment of full time trained psychiatrists will improve, although it should be possible to assemble a team of visiting specialists. This is urgently needed.

RECOMMENDATION 70

The Committee recommends that psychiatrically trained staff be redeployed to areas of greatest need, supplemented by a team of visiting consultants, and coordinated by a Chief Psychiatrist at Oak Ridge.

As discussed elsewhere in this Report (see Recommendation 56, p.76), the curtailment of admissions of involuntary patients from the regional psychiatric and general hospitals with concomitant bolstering of appropriate services in these facilities for acutely disturbed and violent patients will reduce the pressure on the existing group of physicians.

A further important aspect of the problem of recruitment is the relative lack of interest shown by psychiatric trainees in the forensic sub-specialty. The Ministry of Health should seriously consider designating this area as one requiring special assistance and support and should consult with Departments of Psychiatry in the province to find means whereby the output of trained specialists could be increased. This matter is likely to become increasingly important over the next five to ten years as a number of the province's senior forensic psychiatrists reach retirement age. A further point worth making here is that forensic specialists in Canada, as elsewhere in North America, tend to devote most of their time and energy to court-related assessments and testimony rather than, as in the United Kingdom, with the continuing treatment and management of mentally abnormal offenders. This being the case, existing training programs in forensic psychiatry may need to be encouraged, financially if necessary, to provide more relevant training geared to the needs of the mental health system as well as the criminal justice system.

RECOMMENDATION 71

The Committee recommends that the Ministry of Health consult, as soon as possible, with University Departments of Psychiatry in Ontario in order to find means to increase the number of suitably trained specialists in forensic psychiatry.

B.8.ii. Psychology

Like the Medical Director and the other discipline chiefs at Penetanguishene Mental Health Centre, the Chief Psychologist has his office at the Regional Division. Psychologists and Psychometrists are deployed on the four units at Oak Ridge, each unit having one or more such staff. As far as the Committee could determine, this discipline has relatively little difficulty in attracting capable, trained staff.

B.8.iii. Research Department

At the present time there is a small but vigorous Research Department based at the Regional Mental Health Centre, whose work has concentrated chiefly on Oak Ridge. The full time professional staff are psychologists by training though independent of the Psychology Department. In addition to the high calibre research which the department has consistently produced, the Committee noted that several specialized programs such as the crisis intervention course for attendants, the aversion therapy program for sex offenders, social skills program and arsonists program, were all, at least initially, run as research projects by that department. Also, some of the clinical psychology staff began their careers at Oak Ridge in the Research Department.

B.8.iv. Social Work

It was reported by ward staff that, despite some improvements in recent years, there remains a shortage of trained social workers at Oak Ridge. The Chief Social Worker, who like other discipline heads, maintains his office at the Regional Mental Health Centre, indicated his strong preference for staff trained to the Master's degree level. However, some senior social workers consulted at other facilities suggested that social work training to the bachelor's level may well be sufficient and it is possibly easier to recruit individuals trained to this level. As well, the Committee noted that the skills required for social workers at a somewhat remote maximum security facility may well be different to those required at, for example, an urban community mental health centre.

B.8.v. Vocational, Recreational and Volunteer Services

There were about 55 volunteers at the time of the Committee's visits, who carried out a number of services for patients, the main activity being the Wednesday evening social. Professional recreational staff are not regularly involved in this activity. It was noted that recreational activity is directly dependent upon availability of security staff although the main inhibitor is the absence of facilities noted elsewhere in this report (See Section B.4.iv.). The recreational area is located in the basement of the building. Certain wards are assigned use of this facility at the same time. Activities available include floor hockey, pool, board games and playing cards. It is highly questionable, given the patient population and the limited facilities, whether many patients could reasonably use this area for recreation on a regular basis.

Recreational staff from the Activity Centre and "Ball Shop" are seconded to the yard during particular times of the day but are generally attached to the Activity Centre.

B.8.vi. Nursing and Attendants

The description in Section B.3 illustrates the complexity of Oak Ridge's administrative structure. In the case of the nursing and attendant staff, the problem is compounded by the intermixture of various roles and qualifications of this, the largest group of staff, at Oak Ridge. The deployment of the staff is shown in Table 15.

As discussed in the section on Staff Training, only a very small number of attendants at the time of the Committee's visits had the formal qualification of R.N. (Registered Nurse with the College of Nurses of Ontario). While the Chief Attendant and Assistant Chief Attendant both now hold this qualification, reporting to them is also a Head Nurse responsible for 13 R.N.'s who are deployed in the dispensary and on the four patient care units. All four Area Supervisors and all but one (who has recently received his R.N.) of the Ward

Supervisors have certification as Registered Nursing Assistants. Staff in the Nursing Security Department all have R.N.A. certification. Of the 166 attendant staff on the wards, approximately 45, about 25%, were of "Attendant, Unclassified" status with no nursing qualifications.

Thus, the title "attendant" is very misleading and the Committee has recommended that it be abandoned (see Recommendation 7, p.14). It should be much clearer which staff have direct patient care responsibilities and which are involved primarily in ward security duties.

Patients at Oak Ridge present a unique set of clinical nursing challenges. It would be of immense benefit to the patients if attendants at Oak Ridge were formally schooled in the particular therapeutic models and nursing skills employed with the patients for whom they hold nursing responsibilities. One could then expect a greater professional orientation to their work with the patients.

TABLE 15: NURSING AND ATTENDANT STAFFING, OAK RIDGE, JULY 1984[1]

Units	Ward	Number of Staff	
Attendants			
Forensic	01	22	
	02	19	
Admission	03	22	
	05	22	
Extended Treatment	04	19	
	06	20	
Behaviour Therapy	07	22	(Ward Supervisor, R.N.*)
	08	20	
Security		13	
Activity Centre		6	
Hospital Services			
Outdoor Workers		2	
Part Time		16	(unclassified)
		6	(R.N.A.)
Management		9	(1 Chief*, 1 Assistant Chief*, 3 Secur. Super. 4 Area Super)
Nurses			
Head Nurse*		1	
Ward/Dispensary Nurses*		13	

* Registered Nurses.

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[1] Information provided by Director of Nursing, RMHC, Penetanguishene, July, 1984.

The hospital has adopted a policy, which the Committee has recommended in Section B. 9 be continued, of insisting that the R.N. certificate be required for promotion to Ward Supervisor (the equivalent of a Head Nurse elsewhere) and higher levels of nursing administration.

B.8.vii. Chaplaincy

The hospital's one chaplain is based at the Regional Mental Health Centre. He enlists the help of local colleagues when necessary.

B.8.viii. Occupational Therapy

The Committee, in its visits to facilities comparable to Oak Ridge, noted a far greater emphasis on occupational therapy. Oak Ridge clearly needs to expand its services in this direction, though the Committee appreciated that existing staff make use of very meagre resources (see Recommendation 18, p.25).

B.8.ix. Teaching

One contract teacher is employed at Oak Ridge. In comparable institutions visited by the Committee many more patients were involved in educational programs than at Oak Ridge with correspondingly larger numbers of teaching staff.

B.8.x. Legal-Clinical Liaison Officer

This position was apparently created in recent years primarily in response to the upsurge of legal activism surrounding Oak Ridge patients, especially those held under Warrants of the Lieutenant Governor. The role is thus clearly to present staff and institutional concerns and not to provide legal advice to the patients, an area addressed by legal counsel, the patient advocate and so on. At the time of the Committee's visits, the incumbent of the position chaired clinical conferences and dictated the resulting conference notes, the only part of the patient's clinical record to be received by the Board of Review. While the presence of the Legal-Clinical Liaison Officer was reported to have substantially reduced the contact between harried clinical staff and legal counsel, the Committee questioned whether this is, in fact, desirable. Indeed, the Committee concluded that patients, their lawyers and the Board of Review are entitled to receive direct testimony or consultation with the clinician primarily responsible for the patients' treatment and care rather than through an intermediary, however clinically sensitive and diplomatic. Nevertheless, the Committee was of the opinion that mental health law is now so complex and clinical staff appeared so bewildered by it, that a clear case can be made for redesignation of the Legal-Clinical Liaison Officer explicitly to that of legal counsel to Oak Ridge, with the added responsibility for educating the hospital staff in the relevant areas of the law.

RECOMMENDATION 72

The Committee recommends that the role of the Legal-Clinical Liaison Officer be redesignated to that of legal counsel to Oak Ridge and that this individual also assume an educational role for other staff.

RECOMMENDATION 73

The Committee recommends that the Lieutenant Governor's Board of Review and Central Ontario Board of Review be able, without undue difficulty, to have direct access to the personal testimony of the clinician primarily responsible for a patient's treatment and care at Oak Ridge.

B.9. TRAINING AND QUALIFICATIONS OF ATTENDANT STAFF

The inservice staff training programs operated by the Staff Development Department at the Regional Mental Health Centre at Penetanguishene and available to staff at Oak Ridge are clearly outlined in that Department's printed materials. Because many of the attendant staff have limited or no previous formal preparation for the therapeutic nursing care aspects of their role, a strong educational program is essential at Oak Ridge. Approximately one quarter of the attendant staff were "grandfathered" into the Nursing Assistant position following various lengths of employment.

B.9.i. Background

As noted in Section B.8.vi. (p.90), many of the attendants have roots in a custodial approach to patient care. At the present time, there are approximately 45 persons employed as attendants, roughly 25 per cent of the staff, who are unqualified, carrying the status of "attendant, unclassified". These employees have no previous health care training or expertise in dealing with psychiatric patients. A small portion of this group of attendants are employed specifically in security roles and some perform patient escort services, but the remainder work on the wards as direct patient-care nursing staff either on a full-time or part-time basis.

A mandatory one week orientation for new unclassified attendants focuses exclusively on crisis and security issues, with the exception of one day devoted to nursing. They are taught by the Head of Security.

A common pattern now in the employment of unclassified workers is that they are retained on staff for up to one year. At that time they are asked to choose to continue in employment as a qualified attendant, which necessitates entering an R.N.A. program, usually the one offered by Georgian College. Many leave at this point but some have returned to school and are now employed at Oak Ridge as R.N.A.'s.

Qualified R.N.A. attendants, upon employment, are required to complete a six-week psychiatric nursing assistant course, taught by registered nurses at the Regional Mental Health Centre. Also, they are required to take the Crisis Intervention course and the Medication Administration Course (see below) in addition to the orientation to Oak Ridge security responsibilities outlined above.

B.9.i.a. Medication Course

The Medication Course, which began in 1983, is required for all attendants at Oak Ridge. The Assistant Chief Attendant (R.N.) at Oak Ridge, tests the R.N.A.'s on the wards following their two-day Medication Update Course and again six months later. All full-time qualified staff should, by the time of writing this report, have completed the course.

B.9.i.b. Crisis Intervention Course

A Crisis Intervention Course of five days duration, originally a research project, has been taken over by the Staff Development Department at the Regional Mental Centre, Penetanguishene. This too is mandatory for all qualified attendant staff. Most of the attendant staff at Oak Ridge had taken this course at the time of the Committee's visits. It focuses on the therapeutic and preventative aspects and on verbal skills as well as physical restraint procedures in crisis management. Staff are encouraged to wait until they have had several months experience at Oak Ridge before taking this course as it is felt that they respond better at that time. The course was not offered in 1984 but it was reported to resume the following year. Overall, Oak Ridge staff has been very receptive to the Crisis Intervention Course.

B.9.i.c. Cardio-Pulmonary Resuscitation Training

Cardio-Pulmonary Resuscitation (CPR) training is also required of staff. This was reinforced by a memorandum from the Administration intended for all direct care staff. It is taught at the "heart saver" level and offered approximately every four weeks. At the time of the Committee's survey, 42 of the 200 Oak Ridge attendants were certified at the "heart saver" level. Between May, 1982 and July, 1984, a total of 130 Oak Ridge staff were certified at this level; these figures include all staff at Oak Ridge, attendants and others. For reasons unknown to the Staff Development Department, Oak Ridge staff are not voluntarily coming forward for renewal of the CPR certification. It was, however, reported that in the future all new employees responsible for direct patient care will be required to complete the certification course as it will be presented as part of their initial orientation program.

B.9.i.d. First Aid Course

All new attendant staff will be required to take a six-hour emergency first-aid course provided by the Staff Development Department. This began on a trial basis in January, 1984. It is acknowledged that Oak Ridge, because of chronic staffing problems, may have difficulty freeing staff to participate in the mandatory employee educational program but the Committee strongly supports the move.

RECOMMENDATION 74

The Committee recommends that all Oak Ridge staff be trained in emergency first-aid and cardio-pulmonary resuscitation and that recertification in these procedures at least every two years be a condition of continued employment.

B.9.ii. Library Resources

There is a staff library at the Regional Mental Health Centre with a duplicate card catalogue at Oak Ridge. Also, each ward has been stocked with some basic reference books: Compendium of Pharmaceuticals and Specialties manual, medical directory, psychiatric and medical reference books and so on. The Committee suggests this stock be renewed periodically and other relevant reference books, for example, on mental health nursing, or behavioural management be included.

RECOMMENDATION 75

The Committee recommends that the ward offices at Oak Ridge be provided with reference books pertinent to the programs in operation.

B.9.iii. Barriers to Conducting Staff Education at Oak Ridge

Although the courses offered by the Staff Development Department are relevant to the staff and to the program needs at Oak Ridge, there are difficulties in delivering these amenities to the staff. In the first place the physical plant is quite unsuitable for inservice educational activity, there being no teaching space. Also, because of the design of Oak Ridge it is difficult or impossible to employ audio-visual equipment, and the like, easily in the building. Also important is the varied levels of education and the pervasive shortages of staff so that the wards are highly reluctant or unable to release staff for continuing education programs. There also appeared to be different staff needs on each unit. Furthermore, the preoccupation with institutional security and the previous philosophy of custodial care at Oak Ridge, impedes the acceptance of continuing education directed at therapeutic patient care, knowledge and skills on the part of the attendants.

The educational programs and resources developed by the Staff Development Department were observed to be relevant and well designed. The efforts of the Department to up-grade and supplement the knowledge of clinical skills of the attendant staff at Oak Ridge are commendable. If resources permit, a concerted effort should be made to expand the scope of continuing education for staff at Oak Ridge. Although this is no substitute for formal basic training, there can be no question it is needed at Oak Ridge if staff members are to develop their therapeutic roles.

B.9.iv. Qualilty Assurance at Oak Ridge

Quality assurance concepts and skills are being introduced to the Oak Ridge attendants by staff at the Regional Mental Health Centre. This program was initiated by a one-day workshop in the Fall of 1983. Further introductory concepts were presented in June 1984 on four of the wards: 01, 02, 03 and 05. It is intended to continue these efforts at Oak Ridge since they were well received. In reviewing records, staff have indentified a number of areas requiring further attention. For instance, it was judged that the attendants' charting fell short of accepted standards. This observation was corroborated by the Committee, and it was noted that clinical information in the form of nursing notes was not in evidence frequently or, when recorded was executed at a level below the standards generally employed by nursing personnel in Ontario. The College of Nurses' standards for charting are to be reviewed with the Oak Ridge attendant staff. Oak Ridge must release personnel from regular duties to participate in the timely educational programs offered.

RECOMMENDATION 76

The Committee recommends that Oak Ridge improve the standard of clinical recording carried out by attendant staff through the provision of required training programs and record audit.

B.9.v. Nursing Leadership

Possession of the Registered Nurse (R.N.) diploma has become a requirement for positions of Ward Supervisor, and higher at Oak Ridge. At the time of the

Committee's visits, several staff had been released to attend courses leading to this qualification. The Committee noted that some of those attendants who aspired to this qualification gave the impression of doing so primarily to secure promotion and job security rather than out of any belief that the training would be relevant to their work. However, staff elsewhere at Penetanguishene Mental Health Centre stated that coincident with attending the relevant R.N. courses, such attendants developed more therapeutic attitudes and a sense of professionalism. This is an encouraging observation and the Committee would in any case have had no hesitation in supporting the hospital's requirement which simply brings Oak Ridge into line with other psychiatric hospitals in the province.

RECOMMENDATION 77

The Committee recommends that at least a registration certificate (R.N.) be a requirement for Ward Supervisors and other nursing management positions at Oak Ridge. The hospital must continue to make every effort to assist those who already hold Ward Supervisor positions to improve their qualifications to this minimal level.

In most hospitals, Head Nurses (the equivalent of the Ward Supervisors at Oak Ridge) hold at least the R.N. qualification and are also either required or encouraged by their institution to take the Unit Administration Course sponsored by the Canadian Hospital Association and Canadian Nursing Association. At the time of the Committee's visits, only two staff at Oak Ridge had taken this course, the Chief and Assistant Chief Attendants.

RECOMMENDATION 78

The Committee recommends that in the absence of more advanced management education, completion of the Unit Administration Course co-sponsored by the Canadian Hospital Association and Canadian Nurses Association also be a requirement for all Unit and Ward Supervisors at Oak Ridge.

B.10. ETHICAL ISSUES

There are several issues which come under this general heading. While it is realized that many ethical issues have legal implications, it is worth noting that in many areas the law makes explicit what should in fact be good clinical practice.

B.10.i. Patient Abuse

This is an area where ethical and legal issues are clearly related. Physical mistreatment of patients can occur all too easily in closed mental institutions and the phenomenon has been well documented[1]. Because of criticisms expressed by outsiders to the Committee as well as by the more articulate patients in all parts of the mental health system, the Committee specifically investigated the possibility of abuse, physical or psychological, at Oak Ridge.

Although no instances of physical mistreatment of patients were reported to the Committee during the period of the review and none were observed, a number of patients stated that they had themselves been victims of such abuse in the past, or had witnessed the abuse of other patients. Patients who had left Oak Ridge and who were interviewed by Committee members indicated that, although the hospital administration had become more aware of the problem and was prepared to investigate claims of mistreatment, it nevertheless still sometimes occurs. The patients interviewed indicated that among their group the "upper" wards (Wards 01, 03, 05 and 07), were more notorious with respect to physical abuse. The more articulate patients on Ward 04 stated that from their own experience this ward was the best with respect to being treated well by staff and the absence of physical abuse. Several patients stated that they had learned not to complain. As mentioned previously, patients reported that the attendant staff have a "buddy" system such that if a patient complained about an attendant one of his colleagues would ensure that there were repercussions. The Patients' Advocate at the time of the Committee's visits gave an example reported to him in which the "buddy" would provoke a confrontation in some way with the patient and make a critical note in the patient's file. There were reports from patients of actual physical retribution, although these appeared to be rare. Types of physical mistreatment included general rough handling, banging the patient against metal doors and one specific form of physical abuse referred to as "choking out". The latter "technique" involves seizing the patient by the neck in such a way as to occlude the airway or the blood supply to the brain or the airway resulting in temporary loss of consciousness. Even the more assertive and articulate patients who were interviewed stated that they had learned not to interfere when they observed rough handling. When they did, they were themselves then identified as aggressive, uncooperative and so forth, to the extent of being disciplined by transfer to another ward, restricted in privileges or reported in an unfavourable light when they next appeared, for example, before the Lieutenant Governor's Board of Review.

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[1] See for example Martin J.P. Hospitals in Trouble, Blackwell: Oxford, 1984; Rawls, W.Jr. Cold Storage, Simon and Shuster: 1980 and Ryan, T.& Casey, B. Screw, Southend Press: Boston, 1981.

The patients however, indicated that they saw an improvement in the situation with respect to physical abuse and that senior administrative and attendant staff are aware of the problem and investigate charges and allegations vigorously. The Administrator stated that he has held formal hearings about such allegations. The increased awareness and willingness to investigate charges of mistreatment are vital. The Committee is of the view that the hospital must continue to conduct hearings of this kind. Severe penalties including legal action must be brought against staff who commit such behaviour.

RECOMMENDATION 79

The Committee recommends that the Administrator of Penetanguishene Mental Health Centre continue to formally investigate complaints of abuse against patients and press legal action if necessary.

RECOMMENDATION 80

The Committee recommends that staff members found to conceal abuses by colleagues against patients be regarded as accessories and dealt with accordingly.

Senior attendant staff indicated that, while inroads have been made in dealing with the problem of physical mistreatment of patients, much still needs to be done in reducing the more major psychological abuses. In this category patients refer to instances of taunting and provocation, use of demeaning names and so on. Sometimes this is difficult to distinguish from good natured banter but attendant staff must realize that patients may not see it in this light particularly if, as they assert, even verbal retaliation is likely to be documented by staff as an indication of, for example, anti-authoritarian attitudes, aggressiveness, and so on.

The problems of, and penalties for, patient abuse both physical and psychological, need to be reiterated to staff. Area and Ward Supervisors must take further active steps to confront their staff when they observe such behaviour and initiate thorough investigation of allegations where necessary (see Recommendation 40).

B.10.ii. The Use of Patient Teachers

Patients, who have been at Oak Ridge for some time, who are mentally reasonably stable and who present no immediate management problem, are used, to differing degrees, for various functions on the wards. As with some other characteristics of Oak Ridge, the practice has derived from the unavailability of professional and other staff and from the concepts of the "therapeutic community" in which all patients take responsibility for each other. However, on some units, the Forensic and Admission Units especially, their role serves to extend the control and security functions of the attendant staff. They have been designated by such terms as "staff-patient liaison" and "security coordinator". The functions of the "patient-teachers" in this role are to inform the attendant staff of problem patients and assist the staff in dealing with them. Thus there is clearly a power-status aspect to the "patient-teacher" role. Such a system puts the "patient-teachers" themselves uncomfortably between the staff and the co-patients. Pressure is exerted on the "patient-teachers" to maintain the status quo on the ward and essentially to act as informants on behalf of the attendant staff. On Wards 01 and 05 "patient-teachers" distribute psychological test materials and instruct new patients to cooperate with staff. Although some staff stated that it was not the case, patients clearly indicated that "patient-teachers" sometimes scored the test responses.

The Committee views the present use of "patient-teachers" in these ways as most worrisome. Although the notion of using patients to orientate newcomers to a ward routine may be helpful and uncontentious, the role as an extension of staff in the assessment process and to compensate for staff shortages is not acceptable.

RECOMMENDATION 81

The Committee recommends that the "patient-teacher" role at Oak Ridge be considerably restricted. Those patients should never be placed in a position of authority over other patients, involved in scoring psychological tests or making uncorroborated observations which might be used in Court or hearings. "Patient-teachers" should be most carefully supervised by trained staff (see also Recommendation 44, p.65).

B.10.iii. Confinement

The use of seclusion or confinement has already been discussed in relation to the four patient care units. The excessive use of this management procedure, especially where the intention is clearly punitive, is in the Committee's view blatantly unethical as well as untherapeutic. To state, as for example in written material given to some patients, that "it is strictly up to that patient's behaviour as to how long he remains secluded" is not only inappropriate but clearly penal. It was noted that the Behaviour Therapy Unit has a written seclusion policy though, in the Committee's view, the duration of seclusion is nevertheless excessive. Even this formality was lacking on other units. The Committee considers that a formal policy for seclusion is necessary for use throughout Oak Ridge including guidelines for the use of brief "time outs" as part of a formal behaviour modification program. No patient should be placed in seclusion without simultaneously being placed on close nursing observation. No individual attendant staff should be permitted to order seclusion of a patient. This should be approved by the Ward Supervisor or his deputy and the justification for the procedure fully documented.

RECOMMENDATION 82

The Committee recommends that a formal seclusion policy be developed for use throughout Oak Ridge.

RECOMMENDATION 83

The Committee recommends that patients placed in seclusion (except for brief "time-outs" as part of a formal behaviour modification program) be simultaneously placed on close nursing observation and that such observations be fully documented in the patient's clinical record.

B.10.iv. "Lock-ups" for Administrative Reasons

Patients reported that, if they do not wish to participate in certain ward activities such as going to the yard, chapel services, TV and so on, they are "locked-up" in their rooms. Staff shortages and the need to maintain security are the most frequently cited reasons for this procedure. Nevertheless, depriving a patient of liberty for purely administrative reasons cannot be condoned and the hospital and the Ministry of Health must ensure that staffing levels are increased relative to the number of patients to prevent its necessity.

RECOMMENDATION 84

The Committee recommends that "lock-ups" for administrative purposes be discontinued by improving the staff-patient ratio sufficiently to prevent their necessity.

B.10.v. Visiting Rights

While the Committee acknowledges that there must be practical limits to the numbers of visitors who can be accommodated at the hospital, some patients expressed their view that staff are too restrictive with respect to visiting.

Visiting privileges have been extended since the availability of the new visitors and administration complex which contains a fairly large area for visitors to sit with patients while being monitored periodically by staff and TV camera. Some patients, and the Patient Advocate, raised the issue of "conjugal visits" such as are available to selected inmates in penitentiaries. This would require that a room or facility be set aside for such patients to have extended visits from a spouse and allow intimacies to occur.

RECOMMENDATION 85

The Committee recommends that "conjugal visits" be permitted for suitable patients at Oak Ridge.

Patients did not complain about excessive searching of visitors. Special metal detecting devices are available and, in the event of staff suspicions being aroused, visitors can be prevented entry.

Patients made frequent complaints that they have limited access to telephones. The Committee believes that reasonable telephone contact with the outside world should be permitted and that this right should only be restricted when this amenity is abused, for example, by a person holding excessively long conversations or when threats or otherwise offensive calls are made.

RECOMMENDATION 86

The Committee recommends that greater access to pay telephones be available to Oak Ridge patients.

B.10.vi. Privacy

A large number of patients complained to the Committee members of their general lack of privacy, a problem attributable to the physical structure of the Oak Ridge rooms and wards. As well, it was reported that staff made searches of rooms in the patients' absence, though at the time of the Committee's review, it had been agreed that the searches would be conducted with the patients present. More obvious to any visitor to Oak Ridge is the complete visibility of the toilet facilities in the rooms, so the patients can be viewed performing their private acts of elimination. Although the Committee can appreciate the need to keep acutely disturbed patients under observation, this intrusion into the patients' personal functioning is degrading, unnecessary, and should be minimized as much as possible. Exceptions should be made only in clear interests of safety or security (see Recommendation 9, p.17).

B.10.vii. Patients Performing Maintenance Functions

Occupational and rehabilitation therapy resources are so meagre at Oak Ridge that the use of patients as workers to perform janitorial and building maintenance work has developed. Patients themselves frequently complained to the Committee that they were required to perform this kind of work and, especially, that they were paid so little for doing so. The Committee is of the view that the practice of employing patients in this way should be curtailed and that the hospital employ cleaning staff for this purpose. Concurrently, the occupational therapy and vocational rehabilitation programs need to be expanded to provide more useful employment for patients, employment for which they would receive reasonable remuneration where appropriate (see Recommendations 17 and 18, p.25).

B.10.viii. Censoring of Mail

Documents prepared for the information of patients at Oak Ridge correctly indicate that patients have the right to send or receive mail without it being opened, examined or withheld, except in very special circumstances,[1] for example; when the contents of a communication sent to the patient would likely interfere with the patient's treatment or cause him unnecessary distress, or when a communication written by a patient might be unnecessarily offensive to the recipient, or prejudice the patient's best interests. However, a patient's mail addressed to any lawyer, member of a Regional or Lieutenant Governor's Review

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[1] Mental Health Act R.S.O. 1980, c.262 s.20.

Board or Member of the Legislature may not be opened. Despite this legal assurance, a number of patients expressed reluctance to send letters to Committee members because they believed their confidential communications would be opened by ward staff. Staff consistently denied that this was the case. Nevertheless, patient concerns were sufficiently strong that the Committee must re-emphaize the importance of maintaining privacy of patients' mail.

RECOMMENDATION 87

The Committee recommends that Oak Ridge staff be aware of the right of patients to send or receive confidential written communications and the legally sanctioned conditions allowing negation of this right.

B.11. THE ROLES OF THE OMBUDSMAN AND PATIENT ADVOCATE

In addition, or as an alternative to retaining his own legal counsel, a patient at Oak Ridge has recourse to two other specific external agencies to assist him in dealing with a complaint regarding his treatment or detention at Oak Ridge:

B.11.i. The Office of the Ombudsman[1]

As laid out in S.15(1) of the Ombudsman Act, the broadly defined function of the Ontario Ombudsman is, "to investigate any decision or recommendation made or any act done or omitted in the course of the adminstration of a governmental organization and affecting any person or body of persons in his or its personal capacity". Such an investigation may be made:

(1) on any complaint made to the Ombudsman by any person affected,
(2) on any complaint to him (her) by any member of the Assembly to whom a complaint is being made, or
(3) on the Ombudsman's own motion.

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[1] See Schiffer, M.E. Psychiatry Behind Bars: A Legal Perspective, Butterworths: Toronto, 1982, pages 209 - 219.

Complaints must be made in writing and any such communication to the Ombudsman from a patient in Oak Ridge, as in any other provincial psychiatric facility, correctional institution or training school, must be forwarded immediately, unopened, by the Administration. The Ombudsman may decline to investigate a particular complaint but must inform the complainant of this decision in writing. Where the Ombudsman does investigate, the Administration of the facility must be informed. Such investigation will involve the obtaining of information "from such persons as he thinks fit", and may require any officer, employee or member of any governmental organization to furnish information or produce relevant documents. He or she is empowered to summon before him or her and examine under oath any person who, in the Ombudsman's opinion, is capable of providing relevant information. The Ombudsman may also, following notice, enter any premises occupied by any governmental organization in order to inspect or investigate.

The annual reports of the Ombudsman have frequently reported on investigation of complaints regarding psychiatric hospitals and the Office has effected the transfer or release of patients from Oak Ridge.[1] As noted in the Introduction to this Report, in 1977, the Ombudsman initiated an investigation of the Social Therapy Unit at Oak Ridge.[2]

Based on a sample of interviews with Oak Ridge patients, it was the Committee's impression that few patients seek recourse to the Ombudsman's Office at the present time. Many stated that in their view the Ombudsman "did nothing" and one patient was able to discuss the legislation in great detail, indicating that the Ombudsman does not in fact have a great deal of authority to force an institution to make changes. Although none of the patients interviewed gave it as a reason for not appealing to the provincial Ombudsman, the latter does not deal with those complaints relating to detention on a Lieutenant Governor's Warrant as this system is now under federal jurisdiction.

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[1] First Report of the Ombudsman of Ontario, 1975-6.

[2] The Social Therapy Unit was an intensive therapeutic community program which was disbanded in 1983 when Oak Ridge was reorganized. Remnants of the program however, still exist on some wards at Oak Ridge.

B.11.ii. The Patient Advocate

The Government of Ontario began its Patient Advocate Program in 1982 to provide patients with confidential access to individuals who are not included in hospital staff (though the program is funded by the Ministry of Health) who can, at no cost, speak or act on their behalf. Advocates are not able to order changes in the patient's treatment or discharge patients from hospital but are intended to work with hospital staff in order to resolve the issues about which the patient has complaints or concerns.

The Committee found that information available to patients regarding the Patient Advocate system was adequate. Some patients, having decided that the Ombudsman's Office was not able to effect many changes for them, had already made extensive use of the Advocate. However, it appeared from discussions with patients, and the Advocate at the time of the Committee's visits, that generally it is the more articulate, less mentally impaired and more demanding patients who have employed this resource. On the Behaviour Therapy Unit (BTU) especially and to some degree on the Extended Treatment Unit (ETU), there were long stay patients who appeared to know little or nothing of either the Patient Advocate or Ombudsman and whose mental functions were so compromised as to justify having an individual speak on their behalf. The Advocate, at the time of the Committee's contacts, indicated an awareness of this deficiency, but explained that time was more than filled already without seeking out additional work. Consequently, the Committee is of the view that a second Advocate should be appointed to work specifically and solely at Oak Ridge, allowing his or her colleague to deal exclusively with patients and staff at the Regional Division of Penetanguishene Mental Health Centre, where the present Advocate is based.

RECOMMENDATION 88

The Committee recommends that a Patient Advocate be appointed to work specifically with patients at Oak Ridge.

A variety of patients who were interviewed by the Committee reported that they had sought out the Advocate's advice on some issues. On the whole, the patients were favourably impressed with the Advocate. The only patients who complained were those who were dissatisfied that this person had not so far been able to effect the changes at Oak Ridge which they thought to be desirable. The patients were also well aware of a widely expressed staff hostility to the position of the Advocate. A number of patients indicated that members of the attendant staff had expressed displeasure towards them when they learned that they had complained to the Advocate.

B.12. ROLES OF THE LIEUTENANT GOVERNOR'S BOARD OF REVIEW AND THE CENTRAL ONTARIO BOARD OF REVIEW

These two Boards are legally established to review the continued detention and treatment of patients held on Warrants of the Lieutenant Governor (WLG) and under the Mental Health Act respectively.

B.12.i. The Lieutenant Governor's Board of Review

This Board is established to monitor the progress of patients detained on Warrants of Lieutenant Governor having been found mentally unfit to stand trial or acquitted of charges by reason of insanity at the time of their offence. The status of all persons on a Warrant of Lieutenant Governor must be reviewed within the first six months after the Warrant is issued and at least annually thereafter.

The Lieutenant Governor's Board of Review is chaired by a retired judge of the Supreme Court of Ontario and consists also of a lawyer, two psychiatrists and a lay person, and makes its recommendations through the Chairman to the Lieutenant Governor of the Province.

The Lieutenant Governor's Board of Review adheres to a policy of detachment from matters relating to the day-to-day operation of Oak Ridge. A patient's Warrant simply instructs the hospital "to propound and implement a system of treatment for the rehabilitation and education of the patient". Given the fact that WLG patients remain at Oak Ridge sometimes for lengthy periods it came as no surprise to the Committee that WLG patients who were interviewed held strong views about the Board's recommendations and expressed frustration that they had no means to appeal these decisions, as for example, to a Court.

At this juncture it is worth noting that the difficult issues with which the Lieutenant Governor's Board of Review and the hospital staff must wrestle are inherent in the Warrant system itself. Court findings, particularly with respect to insanity cases, may have little or no relation to the patient's current treatment needs. Also, not all of those found "not guilty by reason of insanity" or "unfit to stand trial" have an interest in treatment and yet find themselves in a psychiatric facility whose role is precisely that. Patients who are not interested in therapy may be sent to Oak Ridge which may not have an appropriate treatment in any case. Conversely, offenders who are treatable and wish to be treated may be convicted and sent to prison. Thus, the insanity "test" does not separate either the treatable from the untreatable or the cooperative from the uncooperative. It is simply a "test" of moral accountability or blameworthiness which, though perhaps valid for other reasons, certainly compounds the difficulties of running maximum security facilities and other psychiatric hospitals.

A further element which makes for difficult clinical-legal problems in this area is the whole matter of the ability to predict dangerousness. The present WLG system relies on this kind of prediction to effect release and yet there is no evidence that mental health professionals can accurately predict dangerousness; in fact, it is salutary to note that the research carried out at Oak Ridge itself amply confirms this position.[1] There is, therefore, no empirical justification for a system which purports to protect the public by keeping those judged to be dangerous incarcerated for indefinite periods. The increased litigiousness of WLG patients and the increasingly adversarial nature of the Review Board hearings at Oak Ridge in recent years is directly attributable in many cases to the indeterminacy of the warrant system, according to some observers consulted by the Committee. Not only this, but the system has given rise to great costs, and patients retain lawyers to attack recommendations of the hospital that they be kept in maximum security. Thus many patients concentrate more of their efforts on legal manoeuvers and procedural wrangling than upon identifying and addressing realistic treatment goals.[2]

[1,2] See Quinsey, V.L., "Long Term Management of the Mentally Abnormal Offender", in Mental Disorder and Criminal Responsibility, edited by Hucker, S.J., Webster, C.D., and Ben-Aron, M.H. Butterworths: Toronto, 1981.

There are, therefore, very many difficult issues relating to the role and functions of the Lieutenant Governor's Board of Review which were beyond the Committee's purview. The current status of the insanity defence and other procedural matters has been very thoroughly and recently reviewed for the Department of Justice of Canada in its Mental Disorder Project.[1] The Committee notes that any changes in the legislation in this area could influence the Ministry of Health's facilities, particularly Oak Ridge, and also alter substantially the nature and type of other facilities. Nevertheless, it must be emphasized that most of the recommendations made in this Report will need to be implemented regardless of any possible legislative reforms. At the present time it should be noted that the present accumulation of WLG cases in the Ontario mental health system is causing some alarm[2].

B.12.ii. Central Ontario Board of Review

This Board is responsible for reviewing the continued detention of patients held at Oak Ridge under the Mental Health Act or may, upon application of hospital staff as laid out in the Mental Health Act, approve the treatment of the patient against his wishes. The Board consists of "three or five members, at least one and not more than two of whom are psychatrists, at least one and not more than two are barristers and solicitors, and at least one of whom is not a barrister or solicitor."

Approximately half of the patients from the patient population at Oak Ridge have been civilly committed under the Mental Health Act of Ontario and were transferred from other institutions, such as regional psychiatric hospitals, or less often, either general hospitals or correctional facilities. The status of civilly committed patients must be reviewed within approximately six and a half months of their commital and may be reviewed each time the informal status is renewed.[1] Federal authorities have the discretion to transfer mentally disordered federal inmates to provincial psychiatric institutions[2]. As a matter of policy, this appears to be done only when there is an agreement on the part of the receiving institution to accept the transfer.

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[1] Sharpe, G., "Mental Disorder Project: Criminal Law Review", Department of Justice, 1984.

[2] Rice, M.E., "Medium and Maximum Security Units for Psychiatric Patients in Ontario", unpublished manuscript, Mental Health Centre, Penetanguishene, 1985.

On average, the length of stay at Oak Ridge for a civilly committed patient is appreciably shorter than for patients held on Warrants of the Lieutenant Governor. See Section B.5.ix. Table 12 (p.35). Most are discharged back to a Regional Psychiatric Hospital or referring correctional institution. Very few patients are released directly from Oak Ridge into the community.

Patients interviewed by the Committee generally appeared to understand the reasons for their continued detention at Oak Ridge and material published by the Ministry of Health about the Mental Health Act was available on the wards.

B.13. PROGRAM DESCRIPTIONS, ADMINISTRATIVE POLICY MEMORANDA, ETC.

As noted earlier, patients generally appeared to have adequate information with respect to the Mental Health Act, the role and functions of the Central Ontario Board of Review, the Lieutenant Governor's Board of Review, the Patient Advocate and Ombudsman for Ontario. Also, a large number of mimeographed papers are provided to patients covering topics such as interpersonal behaviour, psychological defence mechanisms, and so on. The Committee received copies of all this material together with annual reports, program descriptions and administrative policy memoranda. Most of this was very useful to the Committee, though it should be noted that some documents, usually undated, contradicted each other. The Committee assumed that such discrepancies were the result of one document being intended to replace the other, but this was not always clear. The Committee believes there to be merit in collecting all these documents together into a single administrative manual for Oak Ridge and that this be revised each year.

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[1] Ontario Mental Health Act, R.S.O. 1980, c.262. Section 31 permits the patient, or any person on his behalf, to seek a review of the civil commitment on the first certificate of involuntary admission, and on any renewal of the certificate. If the patient does not apply, he is deemed to apply on his fourth renewal. Section 14 (4) allows the first certificate to continue for not more than a two week period. A first renewal is to be for less than one additional month, the second for less than two more months, and the third (and subsequent) renewals for less than an additional three months.

[2] Penitentiaries Act, R.S.C., 1970, cP-6, as amended, S.19.

RECOMMENDATION 89

The Committee recommends that program descriptions, policy memoranda and related material be assembled as a single administrative manual to be revised regularly.

SECTION C

AN ALTERNATIVE

It should be clear from the body of this Report that changes at Oak Ridge are vital both in terms of the physical plant and the administrative structure, service delivery provisions, programing, etc. Drastic renovation of Oak Ridge cannot be postponed. The Committee learned that the hospital undertook to consult the Ministry of Government Services which estimated that it would take 11 to 12 million dollars to refurbish Oak Ridge. In the short term, it may be possible for Oak Ridge to function with minimal structural changes. In the long term, considerably more money will be required as the building is, in the mid-1980's, structurally inappropriate for hospital care and treatment.

Members of the Committee questioned staff at all levels and patients at various stages of recovery about the physical plant. The range of responses was almost bewildering. Some patients, especially those who had been at Oak Ridge or in similar institutions most of their lives, did not as a rule, clamour for improved recreational and vocational facilities. This may be due to the fact that they have received promises of such additions in the past and have become sceptical but is more likely due to their inability to conceptualize something other than what now exists. The latter statement applies much more strongly to the severely disturbed and mentally handicapped than the long term Warrant of the Lieutenant Governor patients who, presently not suffering from any acute mental disorder, are, as might be expected, very bored. Some of the attendant staff too, having spent so many years working in the building find it hard to envision anything different. Few of the attendant staff have had the opportunity to visit similar secure institutions in Canada or elsewhere. As well, they trust the present security at Oak Ridge and, understandably, worry that any new arrangement might not afford their families living in the community the same degree of protection as they currently enjoy. Other members of staff at all levels were, however, anxious to see the commencement of a new building, and the sooner the better.

The Committee is of the view that a new physical structure need not be less efficient with respect to community security. Nevertheless, a change to a therapeutic as opposed to a custodial function, as discussed earlier, implies that the community and the staff have to accept that at times escapes, etc., might occur.[1] The Committee realized that many of the current security measures at Oak Ridge are necessary because of the low staff numbers and sees improvements in this area as essential in the future. As the Committee has already noted many times in this Report, the present physical structure of Oak Ridge inculcates custodial attitudes and behaviour. Maintaining the same physical plant is likely to foster the status quo in this respect.[2] Though Oak Ridge does indeed manage difficult patients, it is also clear to the Committee that there has been enormous cost in terms of patient dignity and that there is an ever-increasing risk of legal action, not to mention appropriate concern from within the mental health professions themselves. It is the Committee's view that, despite the definite improvements which the present administration has been able to achieve and the sympathy which is obviously extended from the accreditation panels towards the facility as unique in this Province, ultimately Oak Ridge is likely to fail reasonable accreditation standards if substantial changes are not made.

The Committee believes that, accepting that changes must occur, several options are available. These are reviewed and discussed in full before giving greater attention to the alternative that is the Committee's strong overall recommendation (Option 4).

C.1. OPTION 1 - Close Oak Ridge and Rebuild a New Similar-Sized Hospital Nearby

Two Committee members visited facilities where this option had been adopted. The Chester Mental Health Centre in Illinois is a modern hospital (built in 1976) which replaced an old maximum security psychiatric facility which was situated nearby. Since the new hospital was built, the former facility has been handed over to the Illinois State Penitentiary system. The new facility is an exemplary modern maximum security hospital though not, in fact, elaborate. Chester shares many of the characteristics of Oak Ridge in that it is approximately a two hour drive from the nearest large urban centre (St. Louis, Missouri) and has suffered from similar difficulties in terms of line staffing and recruitment of professional staff. That hospital solved these problems by retraining the line staff as "security-therapy aides" and adopting a non-medical model for the hospital, whereby, the Superintendent is a former social worker and the administrators on the four clinical units have either Ph.D.'s or M.S.W.'s. Good quality psychiatric support is achieved by employing a team of about eight psychiatrists who visit on a part-time contract basis. One psychiatrist is currently full-time but it seems that even this position is unnecessary given the quality of the psychiatric consultative service and the availability of general practitioners who can deal with emergencies. Some staff problems remain in that the administrators indicated that they had originally experienced enormous difficulties with the line-staff unions, and one unit administrator stated that much of his time is still taken up with handling such matters. For all that, the hospital is very impressive. The emphasis is on education and rehabilitation programs rather than on traditional treatments, although the psychiatric staff and other professionals clearly provide what is necessary. The low-key maximum security building is bright, impeccably clean, well ventilated and equipped with good recreational and educational facilities.

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[1] The Helen Hunley Pavilion in Edmonton and the Forensic Psychiatric Institute in Port Coquitlam, B.C., both secure institutions, allow certain patients, with Board of Review authority, escorted and unescorted passes. From time to time they have elopements but seem to take the view that, given the nature of some patients' disorders, it is trouble that cannot and should not be avoided.

[2] Committee members were struck by the contrast found in visits to rurally-located, long-established, Broadmoor Hospital and surburban, newly-built, Park Lane Hospital in England. Some officials at the latter institution were insistent that it was only through a new building and a new staff that the old mould could be broken. As at Oak Ridge, the division between Broadmoor nurses and patients is marked (superficially by uniforms but likely at a deeper level) whereas at Park Lane it is not nearly so evident. The Chester Mental Health Centre, Illinois, achieved a new building but had to retain the bulk of its previous staff and this necessitated embarking on a massive re-education program for the staff.

Whereas Chester Mental Health Centre is now rebuilt and has been functioning for several years, the Committee visited another maximum security institution of international renown which is undergoing redevelopment in stages. Broadmoor Hospital was built in the mid-nineteenth century about an hour's drive from the city of London, England. Again the similarities with Oak Ridge are quite striking. The small village of Crowthorne near which the hospital is situated, clearly provides most of the manpower and the hospital is the largest employer in the area. It differs from Oak Ridge in that it is sufficiently close to London with its massive population that psychiatric staff have generally been fairly easy to recruit. Nevertheless, the buildings are old and the staff attitudes are still somewhat custodial and punitive. The Ontario Ministry of Health would be wise to take a very serious look at what is now going on at Broadmoor. The plans are to extend the grounds considerably and to rebuild the hospital in stages over the next ten years. Once again, a major problem they are facing is that of changing staff attitudes and goals in preparation for moving this hospital into the twenty-first century. Thus the problems are very similar to those at Oak Ridge.

Most Oak Ridge staff seem to see Option 1 as the most desirable alternative. A new building would certainly be more pleasant in which to work and in which to be a patient. Some positive effects on staff attitudes are likely to occur which would in turn likely improve patient care. The move would be minimally disruptive to the local community which relies heavily on the hospital for employment and, also, would not necessitate rebuilding a hospital in another community where it may not be well accepted. A new hospital may also produce some increase in local pride which no doubt would also help in raising the standards of the hospital. Rebuilding Oak Ridge would be important in an area where unemployment is high and where staff fear loosing their jobs. The local community and staff could continue to feel secure. That is, there would be a maximum security perimeter which would continue to reassure the local population. A new hospital built near the present one could continue to rely on the support services at the existing Regional Hospital and this could reduce operating costs. Furthermore, a new hospital might reasonably be expected to attract new staff.

However, the Committee sees disadvantages in simply rebuilding the hospital. In the first place, such a course would not in itself change staff attitudes and, if this option is adopted, a massive re-educational program would have to be mounted to prepare staff for the changeover. This is what was done at Chester, Illinois, taking approximately four years to retrain all the line staff for their new roles. Similarly, building a new hospital is unlikely, by itself, to solve the specific problem of lack of psychiatric and other professional staff. The model such as that adopted at Chester would seem to be the most logical to adopt if the decision is made simply to rebuild Oak Ridge in the same area.

C.2. OPTION 2 - Demolish Existing Facility and Rebuild a New Hospital with Approximately the Same Bed Capacity Closer to a Large Urban Centre

With this option, it should be possible to obtain trained staff who could presumably be recruited from the larger training centres. It would be feasible to improve the training of ward staff as well as the professional staff. A closer affiliation between mental hospitals and universities is generally regarded as advantageous but is certainly not always necessary. The Helen Hunley Pavilion in Edmonton is an example of a well-functioning and very modern forensic centre which has only recently become affiliated with a university, after several years of independent success. By rebuilding a completely new hospital elsewhere, staff with positive therapeutic attitudes could be employed from the outset. In the new location, it would provide easier access for patients' families, the courts, diagnostic facilities, Boards of Review, etc. For all these reasons, a new facility would be likely to meet proper accreditation standards easily.

Specialized assessments are often of considerable importance when patients from secure facilities are being considered for return to the community. At Oak Ridge at the present time, such assessments are often carried out on a consultative basis by tranfser for short periods to the Clarke Institute of Psychiatry in Toronto and elsewhere. Planning and rebuilding the whole facility in this way would bring the benefit of hindsight as well as the experience which has been gained at other hospitals of a similar kind.

Rebuilding a maximum-security hospital near to a big city is feasible. Committee members visited a number of such facilities. They include the Philippe Pinel Institute in Montreal; Park Lane Hospital near Liverpool, England (a new 500-bed maximum security hospital); the Regional Psychiatric Centre in Saskatoon (in fact, a maximum security peniteniary hospital); the Helen Hunley Forensic Pavilion in Edmonton, and the Forensic Psychiatric Institute at Coquitlam, British Columbia. All of these are on the periphery of large cities. Being close to a large centre would maximize external scrutiny of the facility to help maintain and improve standards. Although these maximum security facilities near big cities seemed to be successful, one must not underestimate the resistance which is encountered from local communities when such facilites are planned or being built.

C.3. OPTION 3 - Demolish Oak Ridge and Rebuild as Two New Facilities Elsewhere

This model would be similar to the one adopted in Ohio. Members of the Committee were intending to visit the facilities in that state but it was not possible to do so before this Report was prepared. In that system, a large, old maximum security hospital was closed and two new, smaller facilities were built close to the cities of Dayton and Columbus. If this model were adopted in Ontario, Oak Ridge would simply be closed completely and two new units of smaller size would be built elsewhere, presumably near cities such as Toronto, London, Ottawa, Hamilton or perhaps Kingston.

The Committee believes it doubtful that Oak Ridge could be closed without considerable local opposition. Also, there is likely much to be gained from retaining a new secure facility in the same location. As well, and not unimportant, is the fact that Oak Ridge has, for all its critics, served the Province well for half a century. It has done its best with very difficult patients and the institution has, despite its low staff-patient ratios and unsatisfactory architecture, attracted some competent and devoted staff over the years. It has shown itself capable of yielding high quality research not easily matched by large universities, and has been capable of self-criticism. The Committee believes that the hospital has made genuine attempts to change and that the Ministry of Health should support these initiatives by adopting the Committee's recommended alternative which follows.

C.4. OPTION 4 - RECOMMENDED ALTERNATIVE - CLOSE OAK RIDGE AND REBUILD TWO SMALLER UNITS, ONE AT PENETANGUISHENE AND THE OTHER NEAR A LARGE URBAN CENTRE.

As noted in the Introduction, the Administrator of the Mental Health Cente, Penetanguishene in September 1983, requested permission from the Ministry of Health to develop a "Master Plan" for the Oak Ridge Division. This "Master Plan" was submitted to the Ministry in May, 1984[1] and made available to the Committee a little time later. Because the matters with which it deals have direct relevance to this Report, its contents were studied with great care. It is encouraging that a "broadly based consensus exists among staff at all levels regarding changes Oak Ridge can and should make". The Plan is concise, well-argued and, in our view, pointing generally in the right direction.

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[1] Task Force Report on the Reorganization of Oak Ridge, April 25, 1984.

C.4.i. Renovate or Rebuild?

The Committee appreciates that the authors of the "Master Plan" may have suggested refurbishing the existing building in order to limit costs and thus make their proposals more readily acceptable to the Ministry at a time of considerable fiscal restraint. As already noted, we understand that an estimate was obtained from the Ministry of Government Services that it would take 11 to 12 million dollars to renovate the facility. However, the Committee is resolutely of the view that the basic building of Oak Ridge is structurally unsuitable and suggests that the additional cost of new, smaller and purpose-built facilities (one at Penetanguishene, the other closer to an urban centre) would in the long run be more effective and probably less expensive to maintain (see Recommendation 8, p.16).

C.4.ii. Size of the Facility

The Committee agrees with the "Master Plan" that strenuous efforts be made to reduce the patient population at Oak Ridge. The plan proposes 175 patients; the Committee estimated 165. However, if adequate alternative facilities were developed elsewhere, probably the population could be reduced still further. Indeed, an ideal figure may be closer to 100 patients.

The method by which this reduction in patient population will be achieved is by ensuring that patients who do not need maximum security conditions are diverted elsewhere. From the Committee's observations, it seems that many, if not most, of the acute admissions of involuntary patients under the Mental Health Act, do not usually justify such a high level of physical security. The chief reason for such inappropriate referrals is generally considered to be lack of suitable facilities elsewhere, especially in Toronto. At one time, Lakeshore Psychiatric Hospital provided a "Special Observation Unit" which dealt with this group of patients who are difficult to manage because of, for example, aggressive behaviour towards themselves or others. Recollections of psychiatrists and others who worked in or who referred patients to that Unit suggest that while it was in existence relatively few involuntary patients were sent to Oak Ridge from the Toronto area. Concerns were expressed about the provision of services for this patient population when the hospital as a whole was scheduled for close-down.[1] Since Lakeshore was closed, there has been a steady increase in the numbers of these patients sent to Oak Ridge. The "medium secure" unit (also referred to as the Special Observation and Forensic Unit) at Queen Street Mental Health Centre did not assimilate these patients, in part, it appears because of its somewhat confused identity and pressure upon it to take patients transferred from Oak Ridge on "loosened" WLG's. Although one of the Committee's members (see footnote page 48) felt that mixing remanded prisoners and patients on Warrants of the Lieutenant Governor with civilly committed patients may be appropriate on clinical grounds, the Committee agreed that in the Ontario system, it is preferable generally to segregate them. The Committee is firmly of the opinion that regional psychiatric hospitals should develop their own facilties for difficult-to-manage, violent or suicidal patients. Professional literature[2] describes examples of the success of such "psychiatric intensive care units" It is really quite extraordinary that our present system in Ontario sends its difficult to manage patients, who require the most skilled, concentrated medical and nursing care, to a remote facility which does not have the requisite staff. The phrase "out of sight, out of mind" certainly seems appropriate here.

The Committee fully acknowledges that some involuntary patients are chronically assaultive. This kind of patient, of whom there are many on the Behaviour Therapy Unit at Oak Ridge at the present time, are often medication-resistant or partially resistant, and are best managed in the kinds of behaviour modification programs which Oak Ridge has developed. The Committee suggests that this program be located in a new unit within the Regional Division, specifically designed for this group of patients (see Recommendation 31, p.48).

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[1] The Closing of Lakeshore Psychiatric Hospital: The Case for Reconsideration, Ontario Public Service Employees Union, 1975.

[2] Goldney, R. et al, "The Psychiatric Intensive Care Unit" British Journal of Psychiatry (1985) 146, 50-54; Crain, P.M. and Jordan, E.G., "The Psychiatric Intensive Care Unit - An In-Hospital Treatment of Violent Adult Patients" The Bulletin of American Academy of Psychiatry (1979) 7, 190-198; Carney, M.W.P. and Nolan, P.A. "Area Security Unit in a Psychiatric Hospital" Brit. Med. Journal (1978) 1, 27-28. Rachlin, S., "On the Need for a Closed Ward in an Open Hospital - The Psychiatric Intensive Care Unit" Hospital and Community Psychiatry (1973) 24, 823-829.

There is a second group of patients who probably do not need to be placed in maximum security. At present, the majority of males who have been found "not guilty by reason of insanity" or "unfit to stand trial" are sent, on a Lieutenant-Governor's Warrant, to Oak Ridge. It is apparently unusual[1] for such patients, at least in Ontario, to be placed initially in medium security, an open ward or even the community. Yet a number of patients whose cases the Committee reviewed could have been placed initially in such settings. After all, psychiatric and other assessments had already been performed on these patients in units which are not designated as maximum security, such as the Clarke Institute's Forensic Service, METFORS, the Royal Ottawa Hospital Forensic Unit, and St. Thomas Medium Secure Unit.

There are of course also patients on WLG's who have been at Oak Ridge and who are believed by the hospital to no longer need maximum security. This group may be larger than is supposed by American studies[2] and the Committee's general impressions and suggests that staff at maximum security facilities tend, for obvious reasons, to be cautious in their recommendations.

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[1] The Lieutenant Governor's Board of Review staff indicated that only 54% of WLG's are returned to Oak Ridge after the first Board hearing. However, data gathered by Dr. Michael Phillips of the Metropolitan Toronto Forensic Service, indicate that 88% of WLG's are sent initially after court to Oak Ridge, most of the rest being women who are detained at the Medium Secure Unit of St. Thomas Psychiatric Hospital.

[2] Heller, M.S., Traylor, W.H., Ehrlich, S.M. and Lester, D., "A Clinical Evaluation of Maximum Security Hospital Patients by Staff and Independent Psychiatric Consultants" Bulletin of American Academy of Psychiatry and Law (1984), 12, 1, 85-92.

C.A.iii. Development of Medium Secure Facilities

The authors of the "Master Plan" propose that sections of Oak Ridge be designated as "medium secure" within the maximum security perimeter. The Committee agrees with this notion and believes that such a section should be used as part of a graded system of privileges contingent upon carefully specified behavioural criteria. Application of this system should provide decision-making boards with much more accurate assessments of the patient's ability to control his behaviour in the less stringent environment of a true medium secure unit.

The Committee is aware of the dramatic increase in the total numbers of patients on WLG's and the consequent increase in pressure for medium security facilities.[1] There seems little doubt that the Ontario system tends to retain its WLG's in secure conditions for longer periods than elsewhere.[2] Whether or not this trend will continue depends, as far as can be determined, upon whether or not the Lieutenant-Governor's Board of Review relaxes its policies with respect to loosening and vacating Warrants. This, in turn, is linked to the availability of alternative placements for the patients.

Medium secure units have been proposed at Kingston and Whitby Psychiatric Hospitals (at the latter a smaller unit than was originally suggested). If Oak Ridge's population is to be reduced, these units may well be needed. However, the Committee emphasized in Recommendation 2 that the role and functions of such units must be identified before embarking on this program.

Furthermore, Toronto itself, the source of a large number of the patients in the system, has virtually no adequate secure facilities for the treatment of Lieutenant Governor's Warrant cases. The Clarke Institute of Psychiatry Forensic Unit treats very few WLG's because of the pressure on the beds to take Warrant of Remand assessments which better suits its primary academic function. Similarly, METFORS was set up to carry out pre-trial assessments for the Judicial District of York. As has already been indicated, Queen Street's "Special Observation and Forensic Unit" seemed to have had difficulties right from the start. There is thus a strong case for developing a very secure facility in Toronto involved in the management of WLG's, not only as in-patients but also with a follow-up program. Exemplary programs of this kind already exist in British Columbia and Alberta.

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[1] See Rice, M.E., "Medium and Maximum Security Units for Psychiatric Patients in Ontario", unpublished manuscript, Mental Health Centre, Penetanguishene, 1985.

[2] Webster, C.D., Phillips, M.S. and Stermac, L., "Persons Held on Warrants of the Lieutenant-Governor in Canada" Canada's Mental Health, in press. Hodgins, S., "A Follow-Up Study of Persons Found Incompetent to Stand Trial and/or Not Guilty by Reason of Insanity in Quebec" International Journal of Law and Psychiatry, (1983), 6, 399-411.

C.4.iv. Treatment and Rehabilitation Programing

The Committee insists that patients should not only consent to their involvement in specific programs but actually make written application to participate. Furthermore, many such programs should, as they are now, be time-limited. Even with increased program planning and implementation, the Committee recognizes that certain patients will either be incompetent to consent or to apply for such programs and that others will be disinclined to volunteer. Consequently, there should remain a substantial number of beds for "extended rehabilitation". The Committee urges against identifying these beds for treatment but would place emphasis on education, occupational therapy, vocational rehabilitation and recreation. This is a prominent feature of modern maximum security facilities and the Committee noted, on its site visits, particularly impressive programs at Chester Mental Health Centre in Illinois and Park Lane Hospital near Liverpool, England. Oak Ridge staff have boxed themselves into a corner by continuing to respond to the demand for "treatment" for patients who are either untreatable or who strenuously decline therapy.

The Committee agrees with the suggestion in the "Master Plan" of an increased role for occupational therapists and also strongly recommends a recreational centre with gymnasium, swimming pool, etc., to be part of the new Oak Ridge. Classrooms and other space for educational programs are also vital (see Recommendations 3-18, pp.11-25).

The Committee's own crude estimates and breakdown of beds and program requirements for a new Oak Ridge facility are:

Extended rehabilitation[1]	4 modules of 15 patients	= 60
Special treatment programs		
Sex offenders	2 modules of 15 patients	= 30
Arsonists	1 module of 15 patients	= 15
Assaultives	4 modules of 15 patients	= 60
TOTAL		165 beds

C.4.v. Administrative Structure

The current administrative structure at Oak Ridge requires radical reorganization. The tenacious adherence to a "traditional" medical model with preference for physicians, irrespective of leadership or management skills, as Unit Directors, is in sharp contrast to the virtual absence of physicians with the requisite level of training in psychiatry. Further, the physical structure of the building with eight long wards militates against satisfactory sub-division into smaller program units or modules with their own program directors. Facilities located near large cities such as Montreal, Edmonton, London and Liverpool have little or no difficulty in maintaining medical leadership because they are closer to sources of adequately trained professionals. Remoter facilites have been forced to "demedicalize", as for example at Chester Mental Health Centre. At Chester, a Superintendent who was formerly a social worker, is in charge of several Unit Directors who possess professional qualifications such as M.S.W. or Ph.D and are responsible for about 45 patients each.

This model favours the professional development of non-medical disciplines. But it is merely a rationalization of the situation which has existed at Oak Ridge for many years. Clearly, at least three-quarters of the units essentially rely already heavily on non-medical leadership, with one unit, the Behaviour Therapy Unit, explicitly directed by a psychologist. Two others are in essence run by senior attendant staff rather than their nominal Unit Directors and only one, the Forensic Assessment and Treatment Unit, is clearly under the leadership of a trained psychiatrist. The Committee believes from what it has seen elsewhere, that the esteem of physicians is, if anything, enhanced rather than compromised by such administrative arrangements. The Committee proposes the appointment of a Chief Psychiatrist whose role would include coordination of the activities of a team of consulting psychiatrists of which six to eight would probably be required (see Recommendation 70, p.88). Also it will be important to ensure that financial incentives are sufficient to induce fully qualified consultants to this work.

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[1] Including both maximum and medium secure components.

C.4.vi. Course of Redevelopment

There is no question from the Committee's point of view that the "outmoded facilities" and "inadequate resources" indicated in the "Master Plan" are holding back the necessary evolution of Oak Ridge. The advantage of redevelopment in stages includes spreading the heavy financial burden over a period of time but would also act as an incentive to staff to work towards improving their level of training and changing attitudes to those more appropriate for a modern psychiatric hospital. Staff should only be hired for the new units who have shown themselves willing to adapt to the new therapeutic role. The total time required for the redevelopment program should be ample enough to make the adjustment.

SECTION D

SUMMARY OF RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

PAGE

B.2 THE ROLE OF OAK RIDGE 8

Recommendation 1 10

The Committee recommends that a central coordinating policy and bureau be developed to allocate patients referred by the Courts on Warrants of Remand to an apropriate assessment facility.

Recommendation 2 11

The Committee recommends that before the number of medium secure unit beds is increased, the Ministry of Health clarify, as soon as possible, the expected roles and functions of such units.

Recommendation 3 11

The Committee recommends that once the roles and functions of the medium secure units has been defined, the number of such units be increased if necessary.

Recommendation 4 12

The Committee recommends the establishment of a high-level inter-ministerial body responsible for the overall planning and coordination of resources and service delivery to mentally abnormal offenders.

B.3 THE ADMINISTRATIVE STRUCTURE OF OAK RIDGE 12

Recommendation 5 13

The Committee recommends that Oak Ridge have its own autonomous administrative structure.

Recommendation 6 14

The Committee recommends that an Executive Board be appointed to oversee the operations of Oak Ridge, responsible to the Ministry of Health.

Recommendation 7 14

There should be a clearer distinction in the Oak Ridge administrative organization between staff whose role is primarily related to security functions and those whose role and training is appropriate to nursing care. The title "attendant" should be abandoned and those staff without nursing qualifications redesignated as "security aides".

B.4 THE PHYSICAL PLANT 15

B.4.i. The building as a whole 15

Recommendation 8 16

The Committee recommends that the building be replaced in stages by a more modern, purpose-built facility or facilities.

B.A.iii. Patients' Living Areas 17

Recommendation 9 17

The Committe recommends that patients' rooms, wherever possible, afford adequate privacy.

Recommendation 10 17

The Committee recommends that patient accommodation provide graded levels of physical security.

B.A.iv. Recreational and Leisure Facilities 17

Recommendation 11 18

The Committee recommends that the staff-patient ratio be increased to allow more frequent outdoor exercise opportunities for patients.

Recommendation 12 18

The Committee recommends that attendant staff be trained and encouraged to participate with patients in their recreation.

Recommendation 13 20

The Committee recommends that the deficiency of recreational amenities be rectified by giving this aspect very high priority in plans for rebuilding the facility.

B.A.vi. Attendant Staff Amenities 20

Recommendation 14 21

The Committee recommends that the Ministry or its agents discuss with Oak Ridge attendant staff representatives, the amenities which should be incorporated in the design of a new building.

B.A.vii. Facilities for Diagnostic and Therapeutic Programs 21

Recommendation 15 22

The Committee recommends that ample facilites for diagnostic and therapeutic purposes be made available in plans for rebuilding Oak Ridge.

B.A.viii. Facilities for Educational Programs 22

Recommendation 16 22

The Committee recommends that much greater emphasis be placed on educational programming at Oak Ridge and that facilities be included in plans for rebuilding the hospital.

B.A.ix. Facilities for Rehabilitation Programs 22

Recommendation 17 25

The Committee recommends that the hospital recruit employees to carry out maintenance, food service and housekeeping duties.

Recommendation 18 25
The Committee recommends that facilities for occupational therapy and vocational rehabilitation at Oak Ridge be substantially improved. This component must receive high priority when plans to rebuild the facility are being drawn up.

B.4.x. Chapel 25

Recommendation 19 26
The Committee recommends that a proper chapel be included in plans for rebuilding Oak Ridge.

B.4.xiii. Physical Space for other Programs and Services 26

Recommendation 20 27
The Committee recommends that properly constructed infirmary facilites incorporating consulting and examination rooms, be made available at Oak Ridge.

B.5 THE FOUR PATIENT CARE UNITS 36

B.5.i. Behaviour Therapy Unit (BTU - Wards 07 & 08) 36

B.5..i.c. Unit Program 37

Recommendation 21 39
The Committee recommends that behaviour therapy programs be tailored individually for each patient.

Recommendation 22 39
The Committee recommends that the patient-staff ratio on the Behaviour Therapy Unit be increased to allow more time to be devoted to therapeutic purposes.

Recommendation 23 40
The Committee recommends that patients in the BTU token-economy programs receive remuneration and reward properly proportionate to effort expended.

Recommendation 24 41
The Committee recommends that attendants on the BTU and on other units become more involved with patients, both individually and in groups, and that they be trained for this role.

B.5.i.d. Leadership and Management 41

Recommendation 25 41
The Committee recommends that all attendant staff on the BTU and on other units become fully aware of the clinical histories of the patients in their care.

Recommendation 26 43
The Committee recommends that the Behaviour Therapy Unit while it continues to exist at Oak Ridge, be directed, as now, by a specialist in behavioural management.

B.6.i.g. Use of Confinement 44

Recommendation 27 46
The Committee recommends a 24-hour time limit for seclusion be instituted in the Behaviour Therapy Unit.

Recommendation 28 46
The Committee recommends that detention in seclusion beyond 24 hours within the BTU be permitted only on the authority of the Administrator in consultation with the Medical Director or his deputy.

Recommendation 29 46
The Committee recommends that all uses of seclusion throughout Oak Ridge be reviewed at least monthly by the Administrator and Medical Director.

B.6.i.h. Ethical and Legal Issues 46

Recommendation 30 47
The Committee recommends that the Patient Advocate's Office be more regularly involved with patients on the BTU around issues of consent to treatment.

B.6.i.j. Other Issues 47

Recommendation 31 48
The Committee recommends that violent civilly committed patients referred from provincial psychiatric hospitals should be managed outside Oak Ridge at a purpose-built facility within the Regional Division, Penetanguishene Mental Health Centre.

Recommendation 32 49
The Committee recommends that if civilly committed patients have to continue to be accommodated within Oak Ridge over the short term, their lengths of stay be limited through careful negotiation in advance of admission.

B.6.ii. The Extended Treatment Unit (ETU - Wards 04 & 06) 49

B.6.ii.a. Function 49

Recommendation 33 50
The Committee recommends that programs for patients on the ETU be individualized and redesigned to make them more generally relevant to life in other hospitals and the community.

B.6.ii.b. **Patient Characteristics** 50

Recommendation 34 53
The Committee recommends that the policy of hiring female attendant (nursing) staff for the ETU and elsewhere at Oak Ridge be extended.

B.6.ii.c. **Programs** 54

Recommendation 35 54
The Committee recommends that the staff-to-patient ratio on the ETU be increased in order that established programs can actually be offered with sufficient frequency and intensity.

Recommendation 36 55
The Committee recommends that patients on the ETU and elsewhere at Oak Ridge be paid appropriately for work completed.

Recommendation 37 56
The Committee recommends that selected patients on the ETU be allowed substantially greater opportunities than at present to learn the essentials of independent living.

B.6.ii.d. **Leadership and Management** 57

Recommendation 38 58
The Committee recommends that a non-medical professional staff member be appointed to strengthen the direction of the ETU in terms of the development, coordination, and evaluation of programs.

B.6.ii.f. **Use of Medication** 58

Recommendation 39 59
The Committee recommends that psychiatric consultation, particularly but not exclusively around medication issues, be provided for ETU patients as soon as possible.

B.6..ii.h. **Ethical and Legal Issues** 59

Recommendation 40 60
The Committee recommends that ETU attendant staff be made more clearly aware of the adverse effects of psychological mistreatment of patients. Unit and Ward administrators must be prepared to discipline staff in these circumstances.

B.6.iii. **Forensic Assessment and Treatment Unit (FATU - Wards 01 & 02)** 61

B.6.iii.b. **Patient Characteristics** 61

Recommendation 41 63
The Committee recommends that forensic assessment facilities providing a higher level of security than is presently available be developed closer to the bulk of the patient population in Metropolitan Toronto.

B.6.iii.c. Programs 64

Recommendation 42 64

The Committee recommends that no "program" should exist at Oak Ridge which potentially permits excessive deprivation of basic necessities of civilized life.

Recommendation 43 65

The Committee recommends that the necessity for routine psychological assessment on Ward 01 be re-examined.

Recommendation 44 65

The Committee recommends that psychological tests be administered and scored only by staff qualified to do so (see also Recommendation 81).

Recommendation 45 65

The Committee recommends that the "silence rule" on Ward 01 be rescinded.

Recommendation 46 66

The Committee recommends that Oak Ridge develop a written policy with guidelines for the use of specialized psychiatric assessment procedures.

Recommendation 47 68

The Committee recommends that the suitability of the Therapeutic Community Program for chronic schizophrenic patients on Ward 02 at Oak Ridge be re-evaluated.

Recommendation 48 69

The Committee recommends that, if the Therapeutic Community Program on Ward 02 is retained, it should be supervised by a professional staff member, trained and experienced in this modality.

B.6.iii.e. Staff Resources 69

Recommendation 49 70

The Committee recommends that, for as long as remand assessments are conducted at Oak Ridge, additional specialized forensic psychiatric expertise be made available to the Forensic Unit.

B.6.iii.g. Use of Confinement 70

Recommendation 50 71

The Committee recommends that the practice of cuffing patients on Ward 02 be discontinued and that alternative procedures for close or continuous nursing observation for instituted.

B.6.iii.h. **Ethical and Legal Issues** 71

Recommendation 51 72
The Committee recommends that the system for monitoring acutely disturbed patients on the Forensic Unit be reappraised with a view of acquiring more modern methods of surveillance.

Recommendation 52 72
The committee recommends that the practice of interrupting water supplies to patient rooms on Ward 01 or on any other unit where this may be done, be used only in exceptional circumstances where justification can be demonstrated. These reasons should be documented clearly in the patient's clinical record.

Recommendation 53 73
The Committee recommends that patients on remand be provided outdoor exercise at least commensurate with that permitted to an individual serving a prison sentence. One hour per day is suggested as the absolute minimum.

Recommendation 54 73
The Committee recommends that mentally competent patients throughout Oak Ridge must give written consent to participate in specific programs or receive specific treatments.

B.6.iv. **Admission Unit (AU - Wards 03 & 05)** 74

B.6.iv.a. **Functions** 74

Recommendation 55 74
The Committee recommends that a mental health system - wide definition of "dangerousness" be developed, together with supporting policies and specific criteria for admission to Oak Ridge.

B.6.iv.b. **Patient Characteristics** 75

Recommendation 56 76
The Committee recommends that more adequate facilities for the acute management of violent psychiatrically disturbed patients be developed at provincial psychiatric hospitals. These are needed with special urgency in Metropolitan Toronto.

B.6.iv.c. **Programs** 76

Recommendation 57 77
The Committee recommends that the role of the "patient-teachers" on the Admission Unit at Oak Ridge be very carefully supervised by trained, experienced professional staff. (see Recommendation 81, p.102)

Recommendation 58 77
The Committee recommends that recording of clinical observations of patients on the Admission Unit document more clearly the presence and progress of psychiatric symptomology and not simply undesirable behaviour.

Recommendation 59 78

The Committee recommends that clear policy and guidelines, including the use of adequate psychiatric consultation, be developed for the use of electro-convulsive therapy at Oak Ridge.

Recommendation 60 79

The Committee recommends that the psychiatric component of the Admission Unit be strengthened through the addition of qualified psychiatric consultants.

B.6.iv.d. Leadership and Management 79

Recommendation 61 80

The Committee recommends that the Admission Unit be reorganized and that it be administered by a professional qualified in program development.

B.6.iv.e. Staffing Resources 80

Recommendation 62 80

The Committee recommends that greater numbers of psychiatrically trained and experienced nurses and a trained social worker be added to the staff complement of the Admission Unit.

B.6.iv.g. Use of Confinement 81

Recommendation 63 81

The Committee recommends that a written seclusion policy be developed by the Admissions Unit and that this be in accord with that used on other units at Oak Ridge.

B.6.iv.h. Ethical and Legal Issues 82

Recommendation 64 83

The Committee recommends that staff on the Admission Unit become better informed of the legal provisions surrounding the issues of consent to treatment. The Clinical-Legal Liaison officer has an educational role in this regard (See Recommendation 72, p.93).

B.7 GENERAL MEDICAL AND HEALTH CARE OF PATIENTS 83

B.7.i. Access to Physcians and Nurses by Patients 84

Recommendation 65 85

The Committee recommends that the number of registered nurses at Oak Ridge performing psychiatric nursing duties, as opposed to general medical and health care, be increased to levels comparable with other psychiatric hositals in Ontario.

B.7.ii. Supervision of Medical and Nursing Services at Oak Ridge 85

Recommendation 66 85

The Committee recommends that the Medical Director, Penetanguishene Mental Health Centre, review the provision of general medical services at Oak Ridge.

B.7.iii Dental Services 85

Recommendation 67 86

The Committee recommends that the provision of dental services to patients at Oak Ridge be increased.

Recommendation 68 86

The Committee recommends that a dental hygenist be added to the Oak Ridge staff complement and that such a person have a role in dental care education.

B.8 STAFF RESOURCES 86

B.8.i. Medicine 86

Recommendation 69 87

The Committee recommends that the administrative structure at Oak Ridge be reorganized and increased reliance be placed on suitably qualified non-medical unit directors.

Recommendation 70 88

The Committee recommends that psychiatrically trained staff be redeployed to areas of greatest need, supplemented by a team of visiting consultants, and coordinated by a Chief Psychiatrist at Oak Ridge.

Recommendation 71 89

The Committee recommends that the Ministry of Health consult, as soon as possible, with University Departments of Psychiatry in Ontario in order to find means to increase the number of suitably trained specialists in forensic psychiatry.

B.8.x. Legal-Clinical Liaison Officer 92

Recommendation 72 93

The Committee recommends that the role of the Legal-Clinical Liaison Officer be redesignated to that of legal counsel to Oak Ridge and that this individual also assume an educational role for other staff.

Recommendation 73 93

The Committee recommends that Lieutenant Governor's Board of Review and Central Ontario Board of Review be able, without undue difficulty, to have direct access to the personal testimony of the clinician primarily responsible for a patient's treatment and care at Oak Ridge.

B.9 TRAINING AND QUALIFICATIONS OF ATTENDANT STAFF 93

B.9.i. Background 94

B.9.id. First Aid Course 95

Recommendation 74 96
The Committee recommends that all Oak Ridge staff be trained in emergency first-aid and cardio-pulmonary resuscitation and that recertification in these procedures at least every two years be a condition of continued employment.

B.9.ii. Library Resources 96

Recommendation 75 96
The Committee recommends that the ward offices at Oak Ridge be provided with reference books pertinent to the programs in operation.

B.9.iv. Quality Assurance at Oak Ridge 97

Recommendation 76 97
The Committee recommends that Oak Ridge improve the standard of clinical recording carried out by attendant staff through the provision of required training programs and record audit.

B.9.v. Nursing Leadership 97

Recommendation 77 98
The Committee recommends that at least a registration certificate (R.N.) be a requirement for Ward Supervisors and other nursing management positions at Oak Ridge. The hospital must continue to make every effort to assist those who already hold Ward Supervisor positions to improve their qualifications to this minimal level.

Recommendation 78 99
The Committee recommends that in the absence of more advanced management education, completion of the Unit Administration Course co-sponsored by the Canadian Hospital Association and Canadian Nursing Association also be a requirement for all unit and ward supervisors at Oak Ridge.

B.10 ETHICAL ISSUES 99

B.10.i.a. Patient Abuse 99

Recommendation 79 100
The Committee recommends that the Administrator at Penetanguishene continue to formally investigate complaints of abuse against patients and press legal action if necessary.

Recommendation 80 100
The Committee recommends that staff members found to conceal abuses by colleagues against patients be regarded as accessories and dealt with accordingly.

B.10.ii.b. **The Use of Patient Teachers** 101

Recommendation 81 103
The Committee recommends that the "patient-teacher" role at Oak Ridge be considerably restricted. Those patients should never be placed in a position of authority over other patients, involved in scoring psychological tests or making uncorroborated observations which might be used in Court or hearings. "Patient-teachers" should be most carefully supervised by trained staff (See also Recommendation 44).

B.10.iii. **Confinement** 102

Recommendation 82 102
The Committee recommends that a formal seclusion policy be developed for use throughout Oak Ridge.

Recommendation 83 103
The Committee recommends that patients placed in seclusion (except for brief "time-outs" as part of a formal behaviour modification program) be simultaneously placed on close nursing observation and that such observation by fully documented in the patient's clinical record.

B.10.iv. **"Lock-ups" for Administrative Reasons** 103

Recommendation 84 103
The Committee recommends that "lock-ups" for administrative purposes be discontinued by improving the staff-patient ratio sufficiently to prevent their necessity.

B.10.v. **Visiting Rights** 103

Recommendation 85 104
The Committee recommends that "conjugal visits" be permitted for suitable patients at Oak Ridge.

Recommendation 86 104
The Committee recommends that greater access to pay telephones be available to Oak Ridge patients.

B.10.viii. **Censoring of Mail** 105

Recommendation 87 106
The Committee recommends that Oak Ridge staff be aware of the right of patients to send or receive confidential written communications and the legally sanctioned conditions allowing negation of this right.

B.11 THE ROLES OF THE OMBUDSMAN AND PATIENT ADVOCATE 106

B.11.ii. The Patient Advocate 108

Recommendation 88 108

The Committee recommends that a Patient Advocate be appointed to work specifically with patients at Oak Ridge.

B.13 PROGRAM DESCRIPTIONS, ADMINISTRATIVE POLICY MEMORANDA, ETC. 112

Recommendation 89 113

The Committee recommends that program descriptions, policy memoranda and related material be assembled as a single administrative manual to be revised regularly.

APPENDICES

APPENDIX A

SITE VISITS

The site visits to facilites other than Oak Ridge included the following:

The Bethlem Royal and Maudsley Hospital, London, England (medium-secure unit)

Brockville Psychiatric Hospital, Ontario (medium-secure unit)

Broadmoor Hospital, Crowthorne, Berkshire, England (maximum security)

Chester Mental Health Center, Chester, Illinois (maximum security)

Clarke Institute of Psychiatry, Forensic Service, Toronto, Ontario (medium security)

Special Observation and Forensic Unit, Queen Street Mental Health Centre, Toronto, Ontario (medium security)

Forensic Psychiatric Institute, Port Coquitlam, British Columbia (maximum security)

Forensic Assessement and Community Services, Edmonton, Alberta (out-patient follow-up)

Helen Hunley Forensic Pavilion, Alberta Hospital, Edmonton, Alberta (full range of security from minimum to maximum)

Institut Philippe Pinel, Montreal, Quebec (maximum security)

Kent Institution, Agassiz, British Columbia (maximum security)

Kingston Psychiatric Hospital, Kingston, Ontario

Menard Correctional Center, Illinois State Penitentiary, Chester, Illinois (maximum security)

Metropolitan Toronto Forensic Service, (METFORS), Queen Street Mental Health Centre, Toronto, Ontario, (medium security)

North Bay Psychiatric Hospital, North Bay, Ontario (medium secure unit)

Park Lane Hospital, Maghull, Liverpool, England (maximum security)

Regional Psychiatric Centre, Saskatoon, Saskatchewan (maximum security penitentiary)

Regional Psychiatric Centre, Abbotsford, British Columbia (maximum security penitentiary)

Regional Treatment Centre, Kingston Penitentiary, Kingston, Ontario (maximum security Penitentiary)

Scott Clinic, Prescot, Liverpool, England (medium secure)

St. Thomas Psychiatric Hospital, St. Thomas, Ontario (medium secure unit)

APPENDIX B

BACKGROUND MATERIALS

There is extensive written material available about Oak Ridge and its various units. Particularly helpful to the Committee were the annual reports of Oak Ridge and the individual units and the internal reviews of the Behaviour Therapy Unit (October 1983) and the Admission Unit (November 1984). Responses by the Unit Directors of the BTU and AU were made available to the Committee.

Unit secretaries and the research department at Penetanguishene Mental Health Centre provided demographic and clinical data on the patient population. The Director of Nursing and Coordinator of the Staff Development Program also provided a large amount of written material.

The Oak Ridge "Master Plan" (April 1984) was perused as were the relevant sections of the Heseltine Report (1983).

In 1983/84 Professor Cyril Greenland and a research assistant compiled, at the request of the Ministry of Health, a thorough search of the professional literature on the subject of "Secure Facilities for Mentally Disordered Offenders". In January 1984 six volumes of reprints were submitted, comprising approximately 90 key articles, as well as a collection of abstracts of these articles. The Chairman and several Committee members reviewed this extensive material as well as the following books and pamphlets:

Beran, N.J. and Hotz, A.M., "The Behaviour of Mentally Disordered Criminals in Civil Mental Hospitals", Hospital and Community Psychiatry (1984), Volume 35, 585-589

Council for Science in Society, Treating the Troublesome, 1981

Goffman, E., Asylums, Penguin Books, Harmondworth, 1961

Gostin, L. Secure Provision, Tavistock Publications: London, 1985

Haines, E.L., The Ontario Lieutenant-Governor's Board of Review, Third Edition, Government of Ontario, 1984

Hucker, S.J., Webster, C.D. and Ben-Aron, M.H. (eds.), Mental Disorder and Criminal Reponsibility, Butterworths, 1981

Lawson, R.B., Greene, R.T., Richardson, J.S., McClure, G. and Padina, R.J., "Token Economy Program in a Maximum Security Correctional Hospital", Journal of Nervous and Mental Diseases (1971), Volume 152, 199-205

Marshall, John, Madness - An Indictment of the Mental Care System in Ontario, Ontario Public Service Employees Union, 1982

Martin, J.P., Hospitals in Trouble, Blackwell, 1984

Milan, M.A. and McKee, J.M., "The Cell Block Token Economy: Token Reinforcement Procedures in a Maximum Security Correctional Institution for Male Felons" Journal of Applied Behaviour Analysis (1976), Volume 9, 253-275

Monahan, J. and Steadman, H.J., Mentally Disordered Offenders, Plenum Press, 1983

Quinsey, V. and Sarbit, B., "Behavioural Changes Associated with the Introduction of a Token Economy in a Maximum Security Psychiatric Institution", Canadian Journal of Criminology and Corrections (1975), Volume 17, 177-182

Rawls, W. jnr., Cold Storage, Simon and Schuster, 1980

Schiffer, Marc E., Psychiatry Behind Bars, Butterworths, 1982

Schwitzbegel, R.K., Legal Aspects of the Enforced Treatment of Offenders, National Institute of Mental Health, Rockville, Maryland, 1979

Smith, R. Prison Health Care, British Medical Association, 1984

Steadman, H.J. and Cocozza, J.J., Careers of the Criminally Insane, Lexington Books, D.C. Heath & Co., 1974

Talbott, J., Death of the Asylum, Grune and Stratton, 1978

Tardiff, K. (ed.), The Psychiatric Uses of Seclusion and Restraint, American Psychiatric Press Inc., 1984

Thornberry, T.P. and Jacoby, J.E., The Criminally Insane, University of Chicago Press, 1979

Toch, H. "The Disturbed Disruptive Inmate: Where does the Bus Stop?" Journal of Psychiatry and Law (1982), Fall, 327-349

Wardlaw, G., "Models for the Custody of Mentally Abnormal Offenders", International Journal on Law and Psychiatry (1983), Volume 6, 159-176

In addition to the above, some of the Committee members examined in considerable detail the many formal publications and unpublished reports of the Research Department, Penetanguishene Mental Health Centre.

APPENDIX C

Legal Aspects of Living Conditions at Oak Ridge*

What is the legal framework within which the Oak Ridge division of the Penetanguishene Mental Health Centre operates? It is part of an accredited public hospital, and houses approximately two hundred and forty men. About one-half of the patients are detained on Warrants of the Lieutenant Governor (WLG's), following an acquittal on criminal charges. There are also a number of men who are on the same type of Warrant, who have yet to be tried, but were found to be suffering from a mental illness to the extent that they were unfit to stand trial. The standard for determining fitness requires that the person be so ill that he is unable to understand such matters as the charges facing him and the nature of the court process, and he is, therefore, said to be unfit to instruct a lawyer.[1] The criteria applied with respect to fitness differ considerably from those relevant to the insanity defence.[2] The latter examines an individual's mental condition at the time of the offence, which may or may not be the same as the person's mental condition at the time of trial. The status of all persons on a Warrant of the Lieutenant Governor must be reviewed within the first six months after the Warrant is issued, and at least annually therafter. However, as a matter of policy, the Lieutenant Governor's Board of Review tries to ensure that those sent to institutions declared "unfit to stand trial" are sent back to court as soon as they improve to the point where a court might find them fit to stand trial.

The Lieutenant Governor's Board of Review is currently chaired by the Honourable E.L. Haines, and the Honourable D. Morand is an alternate Chairman. This Board controls (in most circumstances) in which hospital a patient will reside, what level of security the patient will require, and how long the patient will remain in hospital. The Oak Ridge division of the Penetanguishene Mental Health Centre is classified as a maximum security institution.

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[1] Criminal Code of Canada, s. 543.

[2] Ibid., s.16.

*The assistance of Ms. Gail Czukar in the preparation of this appendix is gratefully acknowledged.

Slightly over one-half of the patient population in Oak Ridge has been civilly committed under the Mental Health Act of Ontario and was transferred from other institutions, such as Regional Psychiatric Hospitals, or less often, either general hospitals or penal institutions. The status of civilly committed patients must be reviewed within approximately six and one-half months of their committal and may be reviewed at each time the involuntary status is renewed.[3] Federal authorities have the discretion to transfer mentally disordered federal inmates to provincial psychiatric institutions.[4] As a matter of policy, this appears only to be done where there is an agreement on the part of the receiving institution to accept the transfer. The Criminal Code allows provincial Lieutenant Governors to transfer an insane, mentally ill, or deficient inmate in a jail to a provincial psychiatric hospital.[5]

On average, the length of stay of civilly committed patients is significantly shorter than those detained on a WLG. Statistics provided by the Research Department at Penetanguishene for the year 1983 indicate that the average length of stay for civilly committed patients is several months, in contrast to a three or four year average for persons detained pursuant to WLG's. Most patients who are discharged from Oak Ridge are transferred either to a Regional Psychiatric Hospital, or back to the referring penal institution. Very few patients are released directly from Oak Ridge to the community.

In any review of this institution, it is important to recall that Oak Ridge staff have little or no discretion over which patients are sent there. Men are sent there regardless of their mental state at the time of transfer, their willingness to accept treatment, and the ability of the institution to treat the patient. In addition, it has to deal with two primary streams of patients whose length of stay (among other things) differs considerably.

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[3] Ontario's Mental Health Act, R.S.O., 1980, c262. Section 31 permits the patient, or any person on his behalf, to seek a review of the civil commitment on the first certificate of involuntary admission, and on any renewal of a certificate. If the patient does not apply, he is deemed to have applied on his fourth renewal. Section 14(4) allows the first certificate to continue for not more than two weeks. A first renewal is to be for less than one additional month, the second for less than two more months, and the third (and subsequent) renewals for less than an additional three months.

[4] Penitentiary Act, R.S.C., 1970, c.P-6, as amended, s.19.

[5] Criminal Code of Canada, s.546(1).

Legal Challenges

Increasing legal challenges, arising both from the evolution of common law, and the implementation of the Charter of Rights and Freedoms, have had considerable impact on this institution. As concern about potential legal action against staff was one of the primary problems articulated in interviews with personnel, a brief examination of the legal framework, both as it exists now and in the future, may be of assistance. Given the number of articulate, intelligent and outspoken patients at this institution, one may reasonably expect a continuing series of challenges to the laws surrounding the operation of Oak Ridge.

Common Law Liability of Staff

Doctors have long complained of being vulnerable to attack either for doing too much, or too little, to help their patients. However, Canadian courts have generally been quite reluctant to find liability arising from allegedly negligent psychiatric care, and have been sensitive to the view that psychiatry is not a science. The standard generally applied by the courts is that, once a doctor undertakes the care of a patient, he is expected to use a level of skill which would be reasonably expected of like professionals. In the context of a specialization, this would mean that a doctor would be expected to use reasonable care, as one would expect of fellow professionals within the specialization.[6]

The law has recognized that a doctor employing reasonable care and prudence is not negligent if damage or injury results from a decrease in the level of security surrounding a patient in order to effect a therapeutic or rehabilitative purpose.[7] At least three Canadian cases have also indicated that a doctor will be held to a higher standard of care if he chooses to employ an innovative style of treatment which is not widely employed.[8]

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[6] See, for example, Haines V. Bellissimo et al (1977), 1 L. Med. Q. 292 (Ont. H.C.); Crits v. Sylvester (1956), 1 D.L.R. (2d) 502 (Ont. C.A.); Aff'd (1956), S.C.R. 991; and G.J. Brandt, "Liability of Custodial Institutions for the Torts of Patient-inmates.", (1977) 1 L. Med. Q. 193.

[7] See Home Office v. Dorset Yacht Co. Ltd., (1970), 2 All E.R. 294 (H.L.) at 304; and Fleishour v. The United States, 244 F. Supp. 762 Ill. Dist. Ct. (1965) at 767.

[8] See McQuay v. Eastwood (1886), 12 O.R. 402 (C.A.); Baills v. Boulanger, (1924) 4 D.L.R. 1083 (Alta. C.A.), at p.1100; Cryderman v. Ringrose, (1977) 3 W.W.R. 109; Aff'd (1978) 3 W.W.R. 481 (Alta. C.A.).

Notwithstanding a statutory provision which would appear to preclude liability on the part of the hospital for negligence in preventing harm caused from one patient to another,[9] a Supreme Court of Canada decision appears to cast some doubt on the extent of the bar on such litigation.[10] However, this area of law has not yet given rise to any significant amount of litigation in Canada.

The Right of the Patient to Treatment

There has not yet been any litigation in Canada in which a patient who desired psychiatric care has brought suit on the basis that he was denied such care. The Ontario Mental Health Act imposes no affirmative obligation on the part of professionals or institutions to provide any particluar level of care. However, with respect to federal inmates, statute provides that an inmate has the right to the medical care which he requires.[11] Another regulation[12] requires that the Commissioner of Penitentiaries "so far as practicable" ensure that the inmate "who is capable of benefitting therefrom" receives (among other things) such psychiatric, psychological, or social counselling as he requires. In British Columbia, legislation requires that the Director of any provincial health facility ensure that every patient in such a facility "is provided with professional care, service and treatment appropriate to his condition, and appropriate to the function of the provincial health ministry..."[13]. It also requires that any person who has charge of a patient and wilfully neglects that patient, commits an offence.[14] It is noteworthy, that this legislation also provides hospitals with some say in their clientele.[15] Alberta's legislation also imposes a duty upon officials to ensure that a patient receives "the diagnostic and treatment services the patient is in need of receiving and the staff of the facility is capable and able to provide".[16]

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[9] Ontario Mental Health Act, op. cit., s.63.

[10] Wellesley Hospital v. Lawson (1977), 76 D.R.L. (3d) 688 (S.C.C.).

[11] Penitentiary Service Regulations, C.R.C. 1978, c.1251, as amended, s.16.

[12] Ibid., Section 20(2).

[13] British Columbia's Mental Health Act, R.S.B.C., 1979, c.256, as amended, s.8.

[14] Ibid., s.17(2).

[15] Ibid., s.18.

In the United States, damages were awarded in at least one case in which it was demonstrated that a lack of treatment within a psychiatric facility led to a far longer period of incarceration than would otherwise have been required.[17] The present likelihood of success in this area, however, must be re-evaluated in light of more recent decisions in the United States which appeared to be moving away from the broad liability found in the 1960's and 1970's.[18]

Consent

Significant concern arises in the way Oak Ridge deals with the issue of consent to treatment. A number of staff, including professional staff, referred to "the recent change in the law" which now requires them to obtain a competent person's consent to treatment. The Committee was distressed that this area of medical jurisprudence is not clearer to Oak Ridge staff. In the absence of substituted consent in the case of an incompetent patient, or a treatment order from the Regional Review Board,[19] unconsented treatment on such a patient involving any physical contact is prima facie evidence of battery. This would leave a doctor open to a potentially very serious law suit.

In fact, the law has long required that a competent patient's consent to treatment be obtained, and on the whole, this principle applies to psychiatric patients as well as other patients. Even some of the medical personnel at Oak Ridge who were aware of the obligation to obtain consent, have adopted procedures which are unlikely to be found adequate should they ever be challenged in court. One doctor interviewed stated that he gave the patient medication without explanation, and unless they threw it back at him, or refused to take it, the consent of the patient was implied. It would appear that there is seldom any explanation provided to patients about the nature of the medication which is prescribed to them, its anticipated side effects, its proposed benefits and the detriment which is anticipated would occur should the patient refuse to take the medication. The Committee recommends that greater steps should be taken to assist the staff in their appreciation of the implications of the law in this area, and assist them in developing a more legally satisfactory procedure. It is particularly important that staff realise that involuntary status does not imply incompetence to consent to treatment and does not remove the legal obligation to seek to obtain the consent of competent patients.[20] There also appeared to be a perception among staff members that, if substituted consent was sought, it would be appropriate to approach relatives serially until one could be found who was agreeable, before resorting to an application before the Regional Review Board. Although this has been a practice in the past,[21] the Committee concludes that it is doubtful whether the legislation authorizes such a procedure.[22]

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[16] Alberta's Mental Health Act, R.S.A. 1980, c.M-13, as amended, s.13(1).

[17] Whitree v. State, 290 N.Y.S. (2d) 486 (Ct.C.L.), (1968).

[18] See Youngsberg v. Romeo 102 S.Ct.2452 (1982), discussed below at ff 27.

[19] See Ontario's Mental Health Act, op. cit., s.35.

Particular concerns have been articulated in medical-legal writings about the voluntariness of consent within the context of a hospital in which virtually every man is held involuntarily. One American case has gone so far as to indicate that in light of the apparently coercive atmosphere in which involuntary patients reside, such a patient is not capable of consenting to psycho-surgery.[23] Although psycho-surgery can never be imposed upon an involuntary patient in Ontario,[24] concern has still been expressed about the ability of involuntary patients to consent to other forms of treatment. However, it is suggested that it is preferable to deal with this vexing problem by recognizing though not condoning, the inherently coercive nature of such a hospital, and attempting to implement such procedures as will minimize the danger of undue pressure being brought upon patients to consent to treatment.[25]

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[20] Sharpe, G., and Sawyer, G., Doctors and the Law, Toronto: Butterworths, 1978, at p.186; Marshall, T.D., The Physician in Canadian Law (2d), Toronto: Carswell, 1979, at p.33; and Schiffer, M., Psychiatry Behind Bars, Toronto: Butterworths, 1982, ff.182.

[21] Re: T. and Board of Review for the Western Region (1984), 44 O.R. (2d) 153 (O.H.C.J.).

[22] Ontario Mental Health Act, op. cit., s.35.

[23] See Kaimovitz ex. rel. John Doe v. Department of Mental Health for the State of Michigan, summarized in Shuman, S.I., Psycho-surgery and the Medical Control of Violence (1977), at ff.221.

[24] Ontario Mental Health Act, op. cit., s.35.

Living Conditions and Legal Implications

This appendix deals primarily with possible legal ramifications of the present physical and living conditions at Oak Ridge. The specific conditions giving rise to concern include:

- (a) Living conditions on the forensic unit (wards 01 and 02)
    - (i) the silence rule (ward 01)
    - (ii) the intermittent use of a 24-hour light in the rooms (ward 01)
    - (iii) the intermittent interruption of all water (including toilet facilities) to rooms in ward 01
    - (iv) the cuffing (tying) of patients together (ward 02)

- (b) General conditions in the hospital
    - (i) the lack of appropriate exposure to fresh air and indoor recreation
    - (ii) temperature extremes in the wards
    - (iii) inadequate ventilation in the wards and other places within the hospital
    - (iv) privacy concerns regarding lack of screens between toilets in patients' rooms.

Of all the matters above, the Committee has concluded that those described in (a) and (b) (i) - (iii) are potentially the most serious in terms of their legal implications.

This appendix will review Canadian jurisprudence, both before and after the Charter, and American and international law, to see if such practices and conditions either singly, or cumulatively, could be characterized as illegal.

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[25] See Schiffer, op.. cit., footnote 20.

At the outset, it is important to recall that the patient population of Oak Ridge includes a great many difficult patients who pose a danger of assaultive behaviour, either towards themselves or to others. It is, therefore, not appropriate to hold such an institution to the same standards one might expect, for example, in a psychiatric wing of a general hospital, or even in a minimum security jail.

There has been almost nothing written in Canada about the legal aspects of conditions within maximum security psychiatric institutions, and only very limited litigation has occurred. Therefore, in an effort to develop a conceptual framework in which to analyze the legal implications of conditions at this facility, analogies were sought. Although there are undoubtedly some differences between the patient population at Oak Ridge and inmates within a maximum security institution, the Committee concluded that prison law could be of some assistance in ascertaining minimal acceptable living standards. Therefore, the regime governing the prisons was examined, both in statutory base, and the numerous levels of regulations and directives which govern almost every facet of life within federal institutions. Particular attention was paid to the standards within the Special Handling Units. These units were created in the late 1970's by the federal penal authorities to deal with the most dangerous inmates. To qualify to be sent to such a unit, the inmate must not only have demonstrated dangerousness while in the community but also have given rise to reasonable cause to conclude that there would be a continuing pattern of danger to himself or others in the absence of the deterrent effect of residence within a Special Handling Unit. All persons convicted of first degree murder are automatically considered for accomodation in such a unit, but many of these inmates are eventually sent to less secure units.

Special Handling Units provide four different security levels, the tightest being the assessment portion, and the loosest providing for a maximum privilege level, still in the context of a highly secure environment. The program is based on the premise that the average inmate will normally spend a minimum of approximately three years within the unit.[26] Divisional instructions regarding the running of such units set out that security is to be considered of primary importance, but the unit also has the mandate to design activities for each inmate in order to assist him in developing his own abilities. Individual plans must be prepared within six months of arrival, setting out what the inmate need do to progress to the next level and to provide a target date for when he might hope to move up to the maximum privilege level. It is interesting to note that even while at the tightest level of security within such a unit, the inmate has a right to one hour outdoor exercise per day and the next level of security provides for one hour outdoor exercise and two and one half hours indoor recreation per day.[27] Such units are stated to be a deterrent, not a disciplinary, measure.

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[26] Commissioner's Directive, 800-4-04.1 (1983-11-18).

Other prisons, including maximum security institutions, have regulations and directives covering the minimum standards for such matters as the following:

(a) Clothing - both type and frequency of change.[28]
(b) Access to natural light.[29]
(c) Access to air circulation.[30]
(d) Pay scale for patients in Regional Psychiatric Centres.[31]
(e) Maximum value of $1,000.00 personal property within cell, restrictions on type of appliances and outlet permitted in cell.[32]
(f) Items which are permitted and items which are contraband within the institution.[33]
(g) One hour exercise per day, excluding time walking to and from meals.[34]
(h) Individual activities to be programmed for disturbed inmates, and a continual review of the status of inmates with psychiatric problems.[35]

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[27] Ibid.

[28] Divisional Instruction, 200-3-04.1 (1984-02-29).

[29] Divisional Instruction, 200-6-03.1 (1963-11-01).

[30] Ibid.

[31] Divisional Instruction, 500-1-08.4 (1983-09-30).

[32] Commissioner's Directive, 600-1-08 (1982-09-10) and Divisional Instruction, 600-01-08.1 (1984-02-29).

[33] Ibid.

[34] Commissioner's Directive, 600-4-07 (1982-07-30) and Commissioner's Directive 600-6-02 (1984-09-26).

[35] Divisional Instruction, 700-1-02.1 (1982-12-31).

There is also a detailed code, both across Canada and in local institutions, which protects the confidentiality of health care records generally, and psychiatric records in particular. These regulations also explicitly provide for a permissible breach of confidentiality if a professional receives, in confidence, information which he believes indicates that an inmate is likely to carry out a threat to the security of the institution, the safety of others, or his own life.[36] There are also detailed policies to be followed when obtaining consent of an inmate to medical, psychiatric, or dental treatment or examination.[37] A definition is provided as to what is considered to be consent and it specifically requires that patients who are undergoing psychiatric care are not to be presumed imcompetent to consent or refuse treatment. The regulations also require that every consent obtained be free, voluntary, genuine and well-informed.[38]

The Committee could not find any prison regulations or directives specifically prohibiting a "silence rule" or the cuffing of inmates together. However, discussions with experts in prison law confirmed our understanding that such practices are not permitted in any federal penal institution.[39] The Committee concludes that it is of grave concern that a silence rule and cuffing occur in a psychiatric hospital when these practices could not be used in a prison. Prisoners also have better access to exercise, and this access is guaranteed by regulations. Concern about such disparities is heightened when it is recalled that approximately one-half of all of the patients at Oak Ridge are civilly committed, and have not been sent following contact with the criminal justice system.

Another matter which may be of equal concern in the future is whether such disparities could give rise to a successful challenge under the Charter of Rights. In April of 1985, the so-called "Equality Provision"[40] came into force which prevents discrimination, among other bases, as a result of mental disorder. Therefore, a challenge could be brought if patients are subjected to harsher conditions following an acquittal on a charge as a result of a mental disorder, than would have been the case had they been convicted and sent to the penitentiary.

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[36] On Consent Generally, see Commissioner's Directive 700-1-07.1 (1983-10-31); Divisional Instructions, 700-1-07.1 (1983-10-31), and 700-1-07.2 (1983-10-31). The specific reference is to s.19 of the last-mentioned Divisional Instruction.

[37] Divisional Instruction, 700-2-02 (1982-11-30).

[38] Ibid., ss.7, 14 to 21.

[39] Discussions with Professor Price, Queen's University, Faculty of Law; David Cole, Barrister, Toronto; and Mrs. Charlene Mandell, Assistant Director, Correctional Law Project, Kingston, Ontario.

[40] The Canadian Charter of Rights and Freedoms, s.15.

The Canadian Association for the Prevention of Crime is in the process of drawing up a detailed set of guidelines to govern both existing institutions, and new facilities which are scheduled to be built. It is of significance that a number of the proposed regulations deal with improving conditions for staff by ensuring greater consultation with them in a number of areas, including the right to make submissions to the administration before the entry of a negative note on the personnel file. It is also explicitly recognized in these regulations that the security and safety of the staff is an important responsibility of the institution, as well as that of protecting the rights of the inmates. It is of interest to note that in two recent cases, workers within penal institutions have joined with prisoners in seeking relief through the courts from the overcrowding, lack of programming and other unacceptable conditions within institutions.[41]

In contrast to the multitude of rules and regulations within Canada's prisons, there are virtually no written regulations setting out the rights and obligations binding staff and patients within Ontario's psychiatric hospital system. It was noted during the Committee's visits to Oak Ridge that concern was raised persistently about the impact of "the law". On a number of occasions, staff asserted that "the law" prevented them from doing their job as they saw fit. On the whole, however, they were unable to provide any specific examples of how "the law" made their job more difficult. In other cases, it was clear that what was curtailing their activities was neither statute nor common law, but rather the result of a policy established by the Administration of the hospital. The general knowledge of the laws applicable to patients in such institutions seemed to be quite low among both professional and non-professional staff. In addition, while a great many patients consider themselves to be well-informed, and assert what they believe to be "their rights", many of their demands, in fact, do not reflect any rights or privileges provided by any statute or common law. It is suggested that an improvement in the knowledge of the facts about legal rights and obligations of both staff and patients, may be of considerable assistance and help to clear away many of the legal myths which are prevalent at Oak Ridge.

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[41] See Collins et al. v. Kaplan et al. (1982), 1 C.C.C. (3d) 309 (Fed.Ct.T.D.); and Re: Hussey et al. and the Attorney General for Ontario et al. (1984), 46 O.R. (2d) 554 (Ont. Div. Ct.).

The Committee proposes that Oak Ridge draws up new guidelines about very basic matters. It is crucial to ensure that there is appropriate consultation with both staff and patients. The guidelines could be reviewed on a regular basis as changes in circumstances, or the law, require. Great sensitivity must be shown to staff who already feel hamstrung by unnecessary legal complications which they view as only creating more paperwork and problems for them and severely restricting their ability to do their jobs properly. It is important to assist the staff in perceiving this as a positive step both for staff and patients. Staff would at least have some statement of principle or guideline to assist them in dealing with new demands by patients rather than dealing with each issue on an ad hoc basis.

When Committee members visited the Regional Treatment Centre within Kingston Penitentiary, they asked staff if they felt that the rules governing all such federal institutions in any way impeded their ability to do their jobs. In fact they felt that, on the contrary, the regulations assisted them as they reduce the amount of conflict with inmates when reference to pre-established policy could settle issues.

An excellent starting point for such guidelines is contained within the recent internal review of the Admission Unit. This review proposed that patients on that ward "have the right to be treated with dignity and understanding and that all unit personnel will behave in accordance with legal and ethical standards at all times".[42] With such an initial statement of principle, helpful guidelines could follow. Some of the matters which might be included could be seen from the list dealing with certain prison regulations referred to above. It might also be of assistance if patients had the right to be advised, at certain intervals, of what is expected of them in order to be recommended for transfer to a less restrictive setting, either within the institution, or to obtain the recommendation of the hospital to move them to another institution.

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[42] Professional Advisory Subcommittee Report Re: Program Review of the Admission Unit, Oak Ridge (November 15, 1984).

INTERNATIONAL LAW

Canada has stated in the United Nations that it would adhere to the United Nations' minimum rules for the treatment of prisoners. These rules require that accommodation meet the needs of prisoners having regard to climatic conditions, the cubic content of air, a minimum amount of floor space, lighting, heating, and accommodation. There is also a requirement that there be enough light to read and appropriate ventilation. A minimum of one hour exercise per day is to be provided unless weather prevents it. The same safety regulations are to exist within the institution as those which would be applied to a worker residing in the community.

Canada has also agreed to be bound by the International Covenant on Civil and Political Rights which entered into force through the United Nations on March 23rd, 1976. Article 7 of that conventions reads, in part as follows:

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

However, to date, most Canadian courts have found that this Convention, and other treaties are not binding, as there has not been any enabling legislation passed.[43] In our federal system, even if the federal government agrees to a convention, or signs a treaty, it does not affect domestic Canadian law, unless legislation is passed in Canada. If the treaty or convention deals with a matter under provincial jurisdiction, it is also necessary to pass provincial laws to implement the treaty.

Recently a case took a different approach to United Nations' commitments. It held that while such commitments are not binding, to the extent they do not differ from domestic law, they are of use as an interpretive aid in determining the meaning of Canadian law. However, to the extent that the two differed, Canadian law would have to be followed.[44]

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[43] See, for example, Collins et al. v. Kaplan et al. (1982), 1 C.C.C. (3d) 309 in which Mr. Justice Dube of the trial division of the Federal Court said that the United Nations convention was not relevant to prison law here as no enabling legislation has been passed.

[44] Re: Mitchell and the Queen (1983), 42 O.R. (2d) 481, 6 C.C.C. (3d) 193 (H.C.J. - Linden, J.).

Recently, in a labour relations case, one of the judges considered how broadly Section 1 of the Charter is to be construed. Section 1 of the Charter states that the rights guaranteed elsewhere in the Charter are subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". Therefore, in some situations a court may hold that rights are narrower than would appear from reading other portions of the Charter. The judge noted that in the proceedings of the Joint Committee considering the proposed Charter, the then Minister of Justice had declared that it was anticipated that our laws, and the Charter, would reflect Canada's international agreements.[45]

Notwithstanding the reference to the intentions of the Minister of Justice in the above-mentioned case, the Charter is now the supreme law of the land, and as it does not explicitly incorporate international agreements or treaties into it, the law in this aspect is still as it was before the Charter; namely, that treaties and conventions only have use as interpretive aids, not as binding authority in Canada.

Article Three of the European Convention on Human Rights states that:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Although there had been a number of cases in the European Commission of Human Rights regarding alleged violations in this section, Committee members were unable to find any reference to these decisions in Canadian jurisprudence dealing with the law in our institutions. As other areas of the law are now looking to European cases to interpret Section 1 of the Charter, it can reasonably be expected in the future that European cases will be considered to be of greater relevance. The Committee did not attempt to research European law exhaustively, but reference to one case might be helpful to demonstrate the type of issues which had been considered and how they were resolved.

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[45] Employees' International Union, Local 204 and Broadway Manor Nursing Home et al and Two other applications (1983), 44 O.R. (2d) 392 per O'Leary, J. at 439 (Div.Ct.).

The action under consideration was initiated as a result of a 1975 complaint lodged by a patient at Broadmoor Hospital, a maximum security hospital in England.[46] The first stage of the proceedings before the Commission involved a decision that it was an appropriate case to be brought before the Commission. It made that decision in 1977, and the further determination of the merits was not made until 1983. This appears in keeping with other European cases which Committee members examined, which appeared typically to take five to six years before a final adjudication of the matter.

The patient complained, among other things, that his rights under Article Three had been violated by the living conditions at Broadmoor. He complained about the hygiene conditions, overcrowding, lack of privacy, and lack of occupational opportunities. The majority of the Commission concluded that although the sanitation was "less than satisfactory" and that some other conditions, particularly the overcrowding problem, were "extremely unsatisfactory", the conditions did not amount to a breach of Article Three. The vote on this issue at the European Commission was eight to five.

CANADIAN LAW

A considerable number of Canadian decisions have considered the impact of the Bill of Rights, and then the Charter, on prison conditions. There has been virtually no litigation relating to conditions within psychiatric institutions. The major case decided under the Bill of Rights involved an allegation that persons detained pursuant to Warrants of Lieutenant Governor were subjected to cruel and unusual treatment. This issue was disposed of, to a large extent, on the ground that there had not been any proof put before the Court that conditions were any worse than those to which convicted persons were exposed nor that anyone was detained on the warrant after they were no longer dangerous.[47] The only case relating to Warrants of Lieutenant Governor since the Charter dealt only with issues of the procedural fairness in hearings before the

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[46] See Y. v. United Kingdon (1977), 10 E.H.R.R. 37 for admissibility decision and B. v. United Kingdom (1983), 6 E.H.R.R. 204 for the decision on the merits.

[47] Regina v. Saxell (1980), 59 C.C.C. (2d) 176 (Ont. C.A.) at pp. 179-186.

Lieutenant Governor's Board of Review.[48] Therefore, again it will be necessary to make analogies to decisions in other areas, particularly to "prison law" to determine how the "pre" and "post" Charter law in Canada might have an impact on Oak Ridge. In order to understand the way in which Canadian law has evolved, it is necessary first briefly to mention the legal framework in which the Canadian courts have dealt with the Bill of Rights and the distinction between that and the way in which they had been interpreting the Charter. Two sections of the Charter will be discussed before turning to American Law.

The Canadian courts interpreted the Bill of Rights as a statute which did not create any new rights, but merely guaranteed those already recognized at the time of its passing. This was termed, in the legal literature, the "Frozen Rights" concept. It was also accepted in these decisions that it was the duty of the court to try to construe existing legislation in such a way as to not conflict with the Bill of Rights, if at all possible. This led to a practice which was termed "reading down" legislation, namely, a tendency to try to construe legislation narrowly in such a way as to permit it to exist side by side with the Bill of Rights rather than strike it down. The Bill of Rights was not a constitution in any sense of the word and was simply treated as a statute like any other.[49]

The section in the Bill of Rights which was invoked in cases relating to prison conditions, minimum sentences, and the death penalty was Section 2(b) which provided that "...no law of Canada shall be construed or applied so as to impose or authorize the imposition of cruel and unusual treatment or punishment". Under the Bill of Rights, the courts wrestled with the meaning of the words "cruel and unusual treatment or punishment" in a number of cases. One of the first issues which arose was whether the punishment or treatment need be both cruel and unusual before any remedy might arise under the Bill of Rights. This so-called "conjunctive interpretation" was favoured by the majority of the

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[48] Re Egglestone and Mousseau and the Advisory Review Board (1983), 6 C.C.C. (3d) 1 (Ont. Div. Ct.).

[49] See, for example, Regina v. Miller and Cockriell (1977) 2 S.C.R. 680, 31 C.C.C. (2d) 177 and Regina v. Saxell (1980), 59 C.C.C. (2d) 176 (Ont. C.A.).

Supreme Court of Canada in one of the key cases decided on this section.[50] That meant, therefore, that even if the conditions were deemed to be terribly cruel but were widespread or had been employed over a long period of time, then the conduct would not come within the prohibition of Section 2(b) of the Bill of Rights. The next interpretation which was favoured was known as the "disjunctive interpretation", namely, that conduct which was either cruel or unusual would satisfy the requirements of the Code. This was the interpretation favoured in the only significant case in which conditions within an institution were labelled cruel and unusual.[51] This was also the interpretation provided in a dissenting judgment in the British Columbia Court of Appeal by Mr. Justice McIntyre, who is now a member of the Supreme Court of Canada.[52]

The third school of thought which found favour with a number of judges dealing with the terms of the Bill of Rights and also with a number who now have dealt with the Charter of Rights, is an approach in which the words "cruel and unusual" are viewed as interacting "...to be considered as a compendious expression of a norm".[53]

In the Bill of Rights cases, and to some extent in the Charter cases, courts have also tried to give substantive meaning to the words "cruel" and "unusual". In a recent decision,[54] the Ontario Court of Appeal quoted with approval an article which had gathered together a number of criteria applied by courts in earlier decisions. The criteria included:

1. Is the punishment such that it goes beyond what is necessary to achieve a legitimate penal (for treatment) aim?
2. Is it unnecessary because there are adequate alternatives?
3. Is it unacceptable to a large segment of the population?

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[50] See Regina v. Miller and Cockriell, supra, per Ritchie,J.

[51] McCann et al. v. The Queen (1975), 29 C.C.C. (2d) 337 (F.C.T.D.) at p. 364.

[52] Regina v. Miller and Cockriell (1975), 24 C.C.C. (2d) 401 (B.C.C.A.) at p. 465.

[53] See footnote 50, supra, at C.C.C. 184, Regina v. Bruce, Wilson and Lucas (1977), 36 C.C.C. (2d) 158 (B.C.C.A.), and Regia v. Shand (1976), 30 C.C.C. (2d) 23 (Ont. C.A.).

[54] Regina v. Langevin (1984), 45 O.R. (2d) 706, 11 C.C.C. (3d) 339 (Ont. C.A.).

4. Is it such that it cannot be applied upon a rational basis in accordance with an ascertained or ascertainable standard?
5. Is it arbitrarily imposed?
6. Is it such that is has no value in the sense of some social purpose such as reformation, rehabilitation, deterrence or retribution?
7. Is it in accord with public standards of decency and propriety?
8. Is the punishment of such a character as to shock the general conscience or to be intolerable in fundamental fairness?
9. Is it unusually severe and, hence, degrading to human dignity and worth?[55]

In a concurring opinion written by the late Chief Justice Laskin in the Bill of Rights' death penalty case,[56] he quoted with apparent approval the statement made in a major Supreme Court of the United States decision dealing with the same issue. In the American decision, a justice of the American Supreme Court had stated that the similar clause in their constitution had at its core the following:

> ...the Cruel and Unusual Punishment Clause prohibits the infliction of uncivilized and inhuman punishments. The State, even when it punishes, must treat its members with respect for their intrinsic worth of human beings. A punishment is "cruel and unusual", therefore, if it does not comport with human dignity...
>
> The true significance of (punishments recognized to be cruel and unusual) is that they treat members of the human race as nonhumans, as objects to be toyed with and discarded. They are thus inconsistent with the fundamental premise of the Clause that even the vilest criminal remains a human being possessed of common human dignity.[57]

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[55] Ibid., at 359 C.C.C., quoting Professor W. Tarnopolsky "Just Desserts or Cruel and Unusual Punishment? Where Do We Look for Guidance?" (1978), 10:1 Ottawa L.R.I.

[56] See footnote 50, at p. 189.

[57] Furman v. Georgia, 408 U.S. 238, 92 S.Ct. 2726 (1972) at 2742, 2743.

A very narrow interpretation under the Bill of Rights resulted in decisions stating that capital punishment,[58] the seven year minimum penalty for importing narcotics,[59] and the conditions within one of Canada's worse prisons,[60] did not constitute cruel and unusual punishment. The only major successful case related to prison conditions within the infamous British Columbia Penitentiary's special confinement unit.[61] In that case, a judge of the Federal Court of Canada concluded that the evidence proved that the conditions prevalent at that time served no legitimate penal function. Even the Director of the institution testified that it would be his preference to see that unit closed. He also found that the expert evidence indicated that the treatment was cruel within their terminology, and the Judge stated that the evidence could support the conclusion that conditions represented punishment which was unnecessry and gratuitous in nature.[62] With respect to how to determine whether punishment or treatment is "unusual" the Judge gave considerable weight to the fact that the evidence indicated that there was, in fact, no penal purpose served by the treatment forced on inmates. He concluded:

> Furthermore, even if conditions in the penitentiary (served) some positive penal purpose, I think that the treatment would be cruel and unusual because it is not in accord with public standards of decency and propriety, since it is unnecessary because of the existence of adequate alternatives.[63]

The Judge in that case concluded that even if the narrow dictionary-type definition is taken which had been used in some of the earlier cases, some aspects of the conditions within the unit met that criterion. The evidence included the fact that the inmates claimed that it was the worst unit they had ever been in, that in other maximum security institutions there was a right to fresh air exercise, and that there was no evidence that the use of a twenty-four hour light was "usual" in other institutions.

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[58] See footnote 50.

[59] See Regina v. Shand, op. cit., footnote 53.

[60] See footnote 51, and Regina v. Bruce, op. cit., footnote 53.

[61] See footnote 51.

[62] This criterion for establishing cruel and unusual punishment was relied upon by Mr. Justice McIntyre's dissenting judgment in Regina v. Miller and Cockriell, op. cit., footnote 52.

[63] Footnote 51, at p. 368.

Distinctions between the Bill of Rights and the Charter of Rights

The first few decisions from the Supreme Court of Canada which have dealt with the interpretation of the Charter of Rights have clearly stated that there is to be an important difference in the approach taken to this constitutional document from that which was employed with respect to the Bill of Rights. Both at the provincial appellate level[64] and in the Supreme Court of Canada,[65] the courts have declared the broad and liberal interpretation which is to be given to the Charter of Rights and Freedoms. As Mr. Justice Dickson[66] stated a few months before he became Chief Justice:

> The task of expounding a constitution is crucially different from that of construing a statute. A statute defines present rights and obligations. It is easily enacted and as easily repealed. A constitution, by contrast, is directed with an eye to the future. Its function is to provide a continuing framework for the legitimate exercise of governmental power and, when joined with a Bill or Charter of Rights for the unremitting protection of individual rights and liberties. Once enacted, its provisions cannot be readily repealed or amended. It must, therefore, be capable of growth and development over time to meet new social, political and historical realities, often unimagined by its framers ... The need for a broad perspective in approaching constitutional documents is a familiar theme in Canadian jurisprudence ... Such a broad, purposive analysis, which interprets specific provisions of a constitutional document in light of larger objects is also consonant with classical principles of American constitutional construction enunciated by Chief Justice Marshall in McCulloch v. Maryland (1918), 17 U.S. (4 Wheat.) 316.

In light of these statements of purpose articulated by the Court, it would appear that they will not necessarily consider themselves bound to follow their earlier Bill of Rights cases when trying to interpret similar words in the Charter. Therefore, the fact that to date quite a narrow construction has been placed on the meaning of the term "cruel and unusual treatment or punishment" may not be a very good indication that it will continue to be the case in the new era ushered in by the Charter.

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[64] See, for example, Regina v. Oakes (1983), 2 C.C.C. (3d) 339 (Ont. C.A.); Regina v. Manninen (1983), 8 C.C.C. (3d) 193 (Ont. C.A.); Re Southam Inc. and the Queen (No. 1) (1983), 3 C.C.C. (3d) 515 (Ont. C.A.); Hunter v. Southam (1983), 3 C.C.C. (3d) 497 (Alta. C.A.).

[65] See, for example, Law Society of Upper Canada v. Skapinker (1984), 11 C.C.C. (3d) 481 (S.C.C.).

[66] Southam v. Hunter (1984), 14 C.C.C. (3d) 97 (S.C.C.) at pp. 105-106.

There would also appear to be a trend in the early Charter cases for the courts to refuse to "read down" legislation by very narrow interpretations in an effort to reconcile conflicts between the legislation and Charter.[67] As already noted under the Bill of Rights that was an approach which was often employed by courts who felt that they had a heavy duty to try to avoid, if at all possible, declaring legislation to be beyond the power of Parliament. In the case upholding the seven year minimum sentence for importation of narcotics, one of the factors noted by the court was that, to the extent that the law might operate unnecessarily harshly in some circumstances, one could rely upon prosecutorial discretion to prevent such hardships.[68]

Finally, the Committee notes the great importance laid on providing the court with evidence as to the specific nature of the conditions involved which are said to be cruel and unusual, and providing the court with expert evidence as to the effects of such conditions. It was the failure to produce specific evidence which, in part, resulted in the failure of a number of cases under the Bill of Rights.[69] Similarly, under the Charter, a case brought to challenge the constitutionality of the practice know as "double bunking" noted that there had been no evidence as to the actual conditions and no proof adduced showing the conditions were deemed by experts to be cruel and unusual.[70] It is important to understand that the case was brought before the implementation of the double bunking policy and the Judge indicated that a suit could be brought back by inmates actually affected by the policy after it had been in effect. The Judge also noted that the federal government proposed to employ double bunking only as a temporary measure until more facilities could be built. He concluded that the practice, even on such a brief basis, was "not to be recommended" and did comment adversely upon the lack of fresh air exercise available, and the poor ventilation within the facility. One of the cases relied upon by the Judge was from the American Supreme Court in which it had been held that permanent double bunking in the context of a maximum security institution did not of itself create cruel and unusual punishment.[71]

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[67] See, for example, Regina v. Oakes, footnote 64, and Southam v. Hunter, footnote 66.

[68] See Regina v. Shand, footnote 53.

[69] See Regina v. Saxell, footnote 47, Regina v. Bruce, Wilson and Lucas, footnote 53.

[70] Collins et al. v. Kaplan et al., footnote 41.

Charter Cases Relating to Cruel and Unusual Punishment or Treatment

Section 12 of the Charter of Rights provides:

> Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Cases interpreting that section have continued to debate whether the term "cruel and unusual" is to be viewed conjunctively, disjunctively, or interactively, as was discussed earlier in this section. To date, the major trend in the cases appears to be to adopt the interactive approach, which necessarily results in a broader interpretation than when one views the words disjunctively.[72] The courts have continued to refer to the Bill of Rights cases for guidance in this area, although none have said that they were bound by the earlier decisions. The courts have still referred to one of the tests for dealing with this section as whether the treatment or conditions would shock standards of decency or propriety, whether there are adequate alternatives and whether there are rational ascertainable standards which could be examined to determine whether the treatment would be imposed in a particular situation.[73]

In keeping with the purposive approach to the Charter described above, courts have appeared to place considerable emphasis on whether the punishment or treatment, in fact, had a legitimate purpose. It is important to see that the courts appear willing to look behind the purpose articulated by institutional officials and are prepared to form their own conclusion. In one federal court case, a judge concluded that notwithstanding assertions by the administration that a prisoner's movement from a lower to higher level of security prison was as a result of security concerns, the true motivation for the transfer was that the applicant had become a nuisance and they wanted to prevent him from assisting others in launching legal challenges.[74] In that case, evidence was adduced indicating that the applicant had suffered a deterioration in his health from being placed in the maximum security environment, and that the emergency care he could receive in that setting was not nearly as satisfactory as it had been in his previous institution. Other specific examples of harm caused to the applicant were proven at the trial. The court ordered that the applicant move back to medium security, and was awarded damages, including damages from mental distress.

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[71] Rhodes v. Chapman, 452 U.S. 311 (1981).

[72] See example, Re Soenen and Thomas et al. (1983), 8 C.C.C. (3d) 224 (Alta. Q.B.) or Mitchell v. Attorney General of Ontario, footnote 44.

[73] See, for example, Bill of Rights cases, such as Regina v. Shand, op. cit., footnote 53, or Regina v. Miller and Cockriell, op. cit., footnote 49, and the similarity of approach in Charter cases, such as Re: Soenen, op. cit., footnote 72, or Regina v. Langevin, op. cit., footnote 54.

Another case of significance dealt with a claim that living conditions of remand prisoners in the Saskatchewan Institution constituted cruel and unusual punishment. One of the important factors in that case was that the evidence proved that such prisoners were usually there on average from seventeen to twenty-four days, although it was conceded that the applicants in the case had been there for a great deal longer. The applicants has access to outside exercise three hours per day and an hour and a half on the weekend. In addition, during the week, they were able to spend close to two hours in gymnasium facilities. They also had access to games rooms for over four hours a day and the ratio of television sets to inmates of one to twelve. The Judge concluded that there was "room for improvement" but that in the circumstances, these conditons did not amount to cruel and unusual punishment.[75] Of potentially greater significance in that case is the fact that the trial Judge ruled that as the inmates had been remanded there before their trial, they could not be "punished" as they had not yet been convicted. It appeared that the Judge was, therefore, prepared to conclude that if conditions at the prison amounted to an effort to "punish" those inmates that he would have declared such activity illegal.

A similar issue arose in Alberta before Mr. Justice McDonald, the former Commissioner in the R.C.M.P. investigation. One of the first distinctions which he pointed out is the difficulty in relying on American cases, because the similar article in their Bill of Rights does not deal with "treatment", only punishment.

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[74] Collins v. Lussier (1983), 6 C.R.R. 87 (F.C.T.D.).

[75] Maltby v. The Attorney-General of Saskatchewan (1982), 2 C.C.C. (3d) 153; appeal dismissed 12 W.C.B. 217 (Sask. C.A.).

Therefore, some of the narrow decisions in the American courts are not necessarily of great assistance in interpreting our section. He also noted that the European Convention on Human Rights contained a section almost identical to that within our Charter. Relying upon the last mentioned decision,[75] he began his analysis by examining whether the conditions amounted to punishment. If so, that would be unconstitutional as remand inmates cannot be punished. He then posed the question whether conditions amounted to "treatment", then whether it amounted to cruel and unusual treatment, and then, finally, whether if they were cruel and unusual, Section 1 of the Charter could be used to limit the inmates' rights.[76] He noted that remand prisoners had access to open exercise for thirty to forty minutes per day and to an indoor gymnasium every other day for one hour. Four days a week they were out of their cells for a least ten hours a day. He thought that in light of the brief stay of remand inmates, these conditions did not amount to being cruel and unusual. He noted, however, that had he viewed the conditions as being cruel and unusual, he would have placed a heavy burden upon the government to demonstate how such conditions could be justified in a free and democratic society.

In conclusion, it would appear that the courts are not going to deem themselves completely bound by their earlier decisions under the Bill of Rights and will probably take a broader view to the interpretation of Section 12 of the Charter than they had under Section 2(b) of the Bill of Rights. An important factor in the success of any challenge to the conditions at Oak Ridge would be the degree to which one would be able to document the conditions, and the availability of expert evidence as to the harmful impact of such conditions. In addition, it would be of great significance whether a preponderance of medical opinion would show that there were any beneficial effects to be gained, and if there were alternatives to such practices as the "silence rule", the cuffing of inmates, the use of a twenty-four hour light and other conditions described earlier.

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[75] Maltby v. The Attorney-General of Saskatchewan (1982), 2 C.C.C. (3d) 153; appeal dismissed 12 W.C.B. 217 (Sask. C.A.).

[76] Re Soenen and Thomas et al., footnote 72.

Section 7 of the Charter of Rights and Freedoms

Section 7 of the Charter states:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

This clause has been termed the "due process" clause. It is under the equivalent section of the American Constitution that most litigation in the United States relating to conditions in mental institutions have been brought. As already noted, American plaintiffs would have less success alleging cruel and unusual punishment because courts have interpreted punishment to relate to the treatment of convicted prisioners serving sentence and, therefore, is not of relevance in dealing with other persons within an institutional context. In Canada, Section 7 has not been used very often in litigation relating to living conditions and similar issues. However, in the case involving the prisoner being transferred from medium to maximum security,[77] the Court held that Section 7 could be invoked when the issue was not an individual's right to complete freedom, but rather the right to a greater freedom within an institutional setting. The Court held that this principle had been previously recognized as involving enough of a liberty interest to require that fair procedures be employed before such a move is made. They noted in that decision that the inmate had not been consulted before his transfer nor had he been given an opportunity to make any submissions with respect to the allegations against him. While it was acknowledged there must be a delicate balance between the need for institutional security and administration without undue interference by a court, there is also still a duty to protect the rights of persons not to be subjected to unfair treatment. This may be of some interest in future in the context of challenges to transfers from less secure to more secure areas within Oak Ridge. It may also be of relevance if a program similar to the Social Adaptation Therapy Program should be re-instituted, and perhaps even to the placement of a patient in the Motivation, Attitude and Participation (M.A.P.) Program.

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[77] See footnote 74.

DISTINCTION BETWEEN CANADIAN AND AMERICAN LAW

There are two articles of the American Constitution which have most often been invoked in litigation relating to conditions within prisons or mental institutions. The 8th Amendment of the American Constitution reads as follows:

> Excessive bail shall not be required, nor excessive fines imposed, nor cruel or unusual punishment inflicted.

Section 1 of the 14th Amendment reads in part:

> ... No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction to equal protection of the law.

As noted, the 8th Amendment does not incorporate the concept of treatment. Therefore, a number of American decisions have limited the 8th Amendment to matters relating to the criminal justice field.[78] For this reason, courts had to seek another avenue through which they could remedy some of the shocking conditions about which there was so much litigation in the 1960's and 1970's. The 14th Amendment, commonly referred as the "due process clause", has been the focus of major decisions in the United States.

There are significant distinctions in the traditional interpretation of the American "due process" clause and the way in which Canadian law has dealt with its clause of the same name. American law has long extended the reach of this clause beyond procedural fairness into an examination of the contents of the decisions as well. This distinction is referred to as the difference between "procedural due process" and "substantive due process". The distinction is of considerable importance when one tries to apply American jurisprudence to the Canadian context as it is not yet clear that Section 7 of the Charter will be held to encompass substantive as well as procedural matters. In the cases decided under the somewhat similar predecessor section of the Bill of Rights,[79] courts had limited the scope of the section to the procedures surrounding how decisions were reached, not the substance of matters.[80] It is not yet authoritatively decided how the interpretation of Section 7 will resolve this particular issue. There are a number of authorities which appear to show that Section 7 will be limited to procedural matters[81] and others expand it to include substantive due process as well.[82] Until this particular issue is resolved, it will be difficult to see whether Section 7 will have much impact on cases dealing with the examination of conditions within psychiatric or penal institutions. However, in light of the decisions discussed earlier, it appears that Section 7 will play a role where the plaintiff is challenging the transfer from one level of security within an institution to a higher level, without regard to the requirements of fairness.

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[78] See, for example, Youngsberg v. Romeo, 664 F. 2d 147 (1980) 3rd Cir., Aff'd 102 S.Ct. 2452 (1982).

It is also helpful to keep in mind, when examining the American cases, what point was actually decided in the case as opposed to the wide variety of issues which are often discussed. The binding authority of a case is based on the application of the stated principle of law to the facts before that particular court, and it extends to facts which are reasonably analogous. However, the fact that a court may comment at length on a constitutional doctrine does not necessarily mean that it is that doctrine upon which the decision is based. Indeed, many American cases cited for their broad statement of constitutional principles, in fact, were decided either on the basis of State statutes governing the operation of institutions, or the mental health system.

Therefore, in light of these distinctions, it is felt appropriate to provide a brief summary with the trends in American law. A detailed examination of the evolution of American law follows later in this appendix. The American experience can be divided into three major trends. The first was a very expansionary trend which began in the late 1960's and continued into the 1970's. Most of these cases were brought in courts run by the federal government and many of them were decided at the level of the federal appellate court, known as Circuit Courts. The United States is divided into thirteen circuits, which are the highest federal courts apart from the United States Supreme Court. These courts were involved in a number of decisions which undertook an extremely detailed examination of conditions at various institutions, and the judgments reflected a willingness to stipulate very thorough guidelines about conditions and treatment programs which would be acceptable. The cases created requirements of adequate ventilation, appropriately personalized treatment programs, highlighted the importance of dignity and privacy in living conditions and the undesirability of having patients employed in menial or maintenance tasks for which they were either not paid or paid next to nothing. The courts would often then adjourn these matters and try to encourage the parties involved in the action to draw up a set of guidelines which would satisfy them, and then later court decisions considered whether the guidelines agreed to by the parties would satisfy the court. In a number of cases, the court still felt the guidelines had not gone far enough even though both parties were prepared to agree to them.

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[79] Section 1 (a) reads as follows:

> ... the right of the individual to life, liberty, security of the person and enjoyment of property, and the right not to be deprived therof except by due process of law.

[80] See, for example, Duke v. The Queen, (1972) C.R. 917, 7 C.C.C. (2d) 474.

[81] See, for example, Re Potma and The Queen, (1983), 41 O.R. (2d) 43 (Ont. C.A.); Re R.L. Crain Inc. et al. and Couture et al., (1984), 6 D.L.R. (4th) 470, (Sask. Q.B.); Aff'd Sask C.A. 1984, unreported.

[82] See Regina v. Young (1984), 13 C.C.C. (3d) 1 (Ont. C.A.); Regina v. Morgentaler (1984), 12 W.C.B. 353 (O.H.C.J.).

The watershed in the evolution of American law occurred in a 1982 Supreme Court of the United States decision.[83] This action was brought on behalf of an involuntarily committed, severely mentally retarded man who had also proven himself to be very dangerous while in custody. At the lower court levels, it had been claimed that he had a right to training *per se*, and that this specifically was a right to whatever training would lead to an increased freedom from restraint within the institution. When the case went to the American Supreme Court, the issue had been narrowed and the claim being asserted was only a right to such treatment as would lead to greater freedom for the patient, not a right to treatment *per se*. The Court recognized that this individual had a right to minimal or reasonable training to ensure his safety and freedom from restraint. However, it noted that this interest must be balanced against the safety rights of others. The Court demonstrated great deference to professional judgment and concluded that it was to the professionals one must look for guidance as to what was involved in reasonable care. It also concluded that the balance between the reasonable safety needs of all residents (including this patient) and the freedom from restraint was to be resolved by indicating that restraints were not to be employed unless professional judgment stated it was required as a matter of safety or training. A concurring decision indicated that the right to treatment would include treatment required to prevent one's self-care skills from deterioriating while in the institution, assuming that anything done within the institution was capable of preventing such a deterioration. Even though the issue was not before them, the Chief Justice stated that there was no right to training or rehabilitation per se, only to provide such treatment or training as to avoid undue restraint on freedom.

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[83] *Youngsberg v. Romeo*, footnote 78.

Later cases interpreting this Supreme Court decision have relied heavily upon the fact that the above was a case in which damages were sought for past conduct as opposed to the majority of such actions which seek an injunction to prevent the continuation of present conduct. The lower courts have stressed that great caution is to be exercised in awarding damages for actions which had never previously been subject to court proceedings and, therefore, the staff might well not have appreciated were unlawful. However, if one were to give injunctive relief preventing the continuation of behaviour, there would not be a similar liability on the part of the staff, unless they continued an activity after the court had warned them that it must cease. Therefore, the lower courts have given a very narrow interpretation to the Supreme Court case, and in a number of decisions remanded back to them for their consideration in light of this landmark decision, they have upheld their earlier judgments. It would, therefore, appear that one must be cautious before drawing too sweeping conclusions from the broad statements in that Supreme Court case.

Another factor which would appear to be a consideration is that the cases coming before the court in more recent days involve far less shocking conditions than many of the American cases in the late 1960's and early 1970's. Some of these cases involved institutions in which there were no available toilet facilities, lights on in cells twenty-four hours a day, many patients were isolated without any effort for treatment for decades, and there was clear evidence of staff brutality against the patients. Faced with such conditions, it is not surprising that courts did everything that they could to find a remedy for those seeking their assistance.

A third factor which cannot be ignored is the change in personnel in the United States Supreme Court over the last decade. The increasingly conservative appointments during the Nixon and Reagan eras have coincided with a notable retrenchment of earlier positions, particularly in the criminal justice field. With the number of positions expected to become vacant during the second Reagan term, one might expect this trend to continue. As justices are appointed for life, the impact of the appointments in the last ten years will be felt for a long time to come. In sharp contrast to the trend, it is suggested that many of the decisions in the last decade indicate that the Canadian Supreme Court is taking a more expansive view of its role than it did before and appears far more willing to cut down legislation which offends the Charter than one might have expected had a similar situation arisen ten years ago. Although it is doubtful that Canadian courts will permit the pendulum to swing as far toward the protection of individual rights as American courts did at one time, the Committee believes it likely that the courts will be taking a fairly broad approach to the Charter. An increased willingness to impose restrictions upon the way in which institutions are allowed to deal with those housed therein has been evidenced since the mid 1970's[84] and can realistically be expected to continue. Even if an application was unsuccessful in having conditions at Oak Ridge declared cruel and unusual, it would appear quite likely, based on previous decisions, that the conditions could be harshly criticized. The extent to which one might seek to change the conditions to prevent such actions is a matter of policy, not law.

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[84] See Martineau v. Matsqui Institution Inmate Disciplinary Board, (1980), 1 S.C.R. 602, 50 C.C.C. (2d) 353.

APPENDIX D

PHOTOGRAPHS OF OAK RIDGE

Photo # 1

APPENDIX D

FRONT GATE - OAK RIDGE

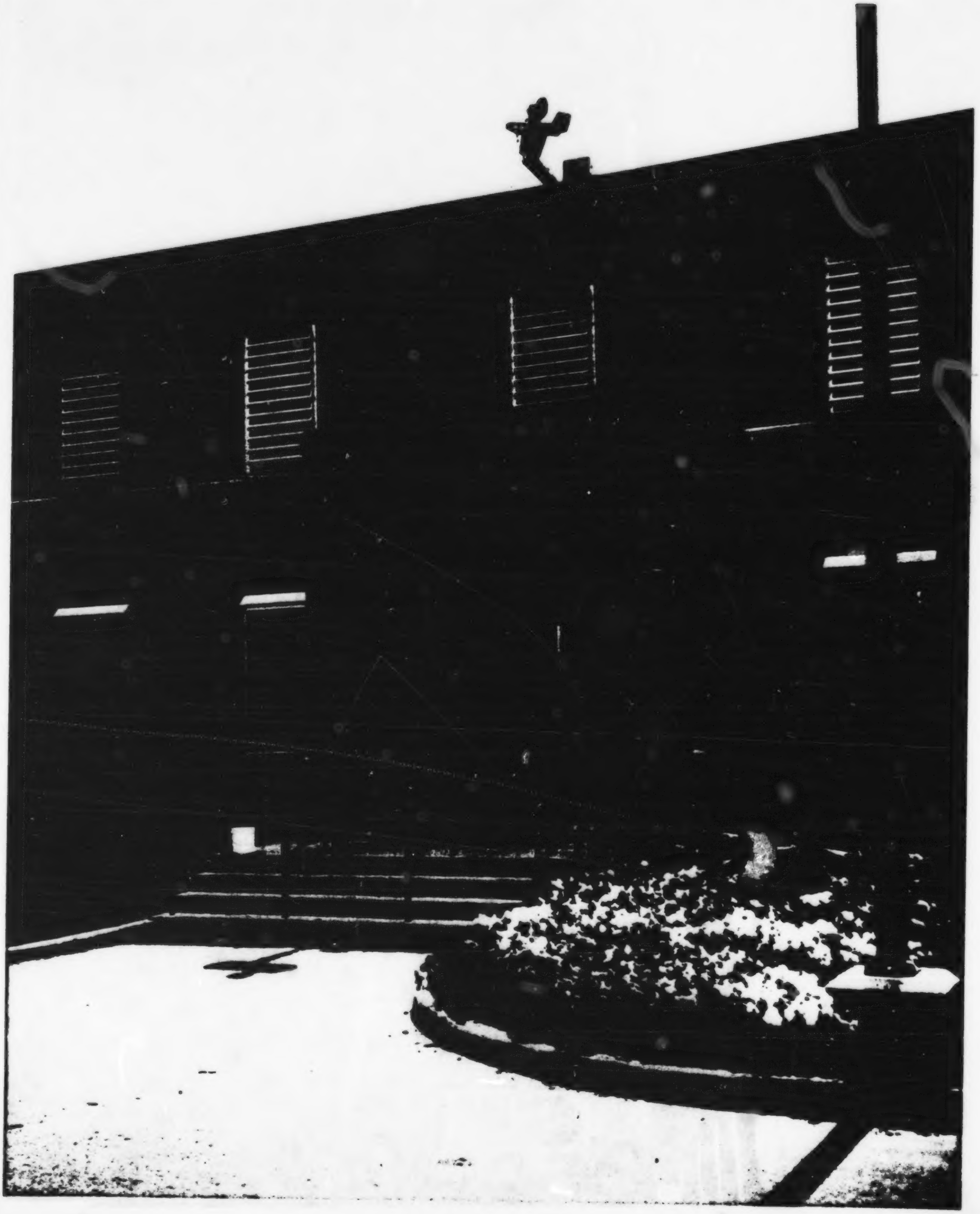


Photo # 2

NEW VISITORS' AND ADMINISTRATION COMPLEX

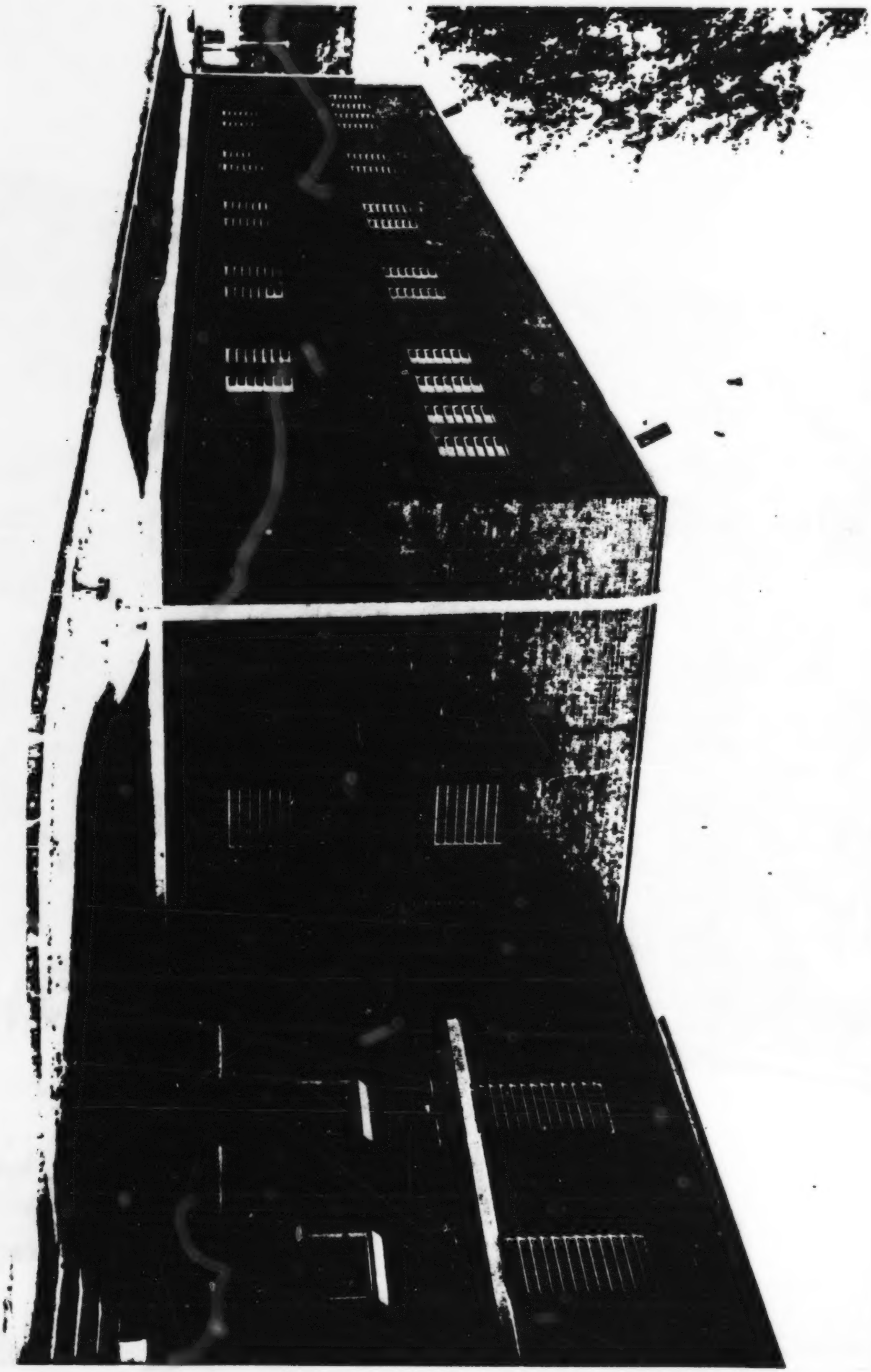


PHOTO # 3

REAR VIEW OF HOSPITAL SHOWING
PERIMETER FENCE AND YARD 1,
(PART OF 2) AND 4

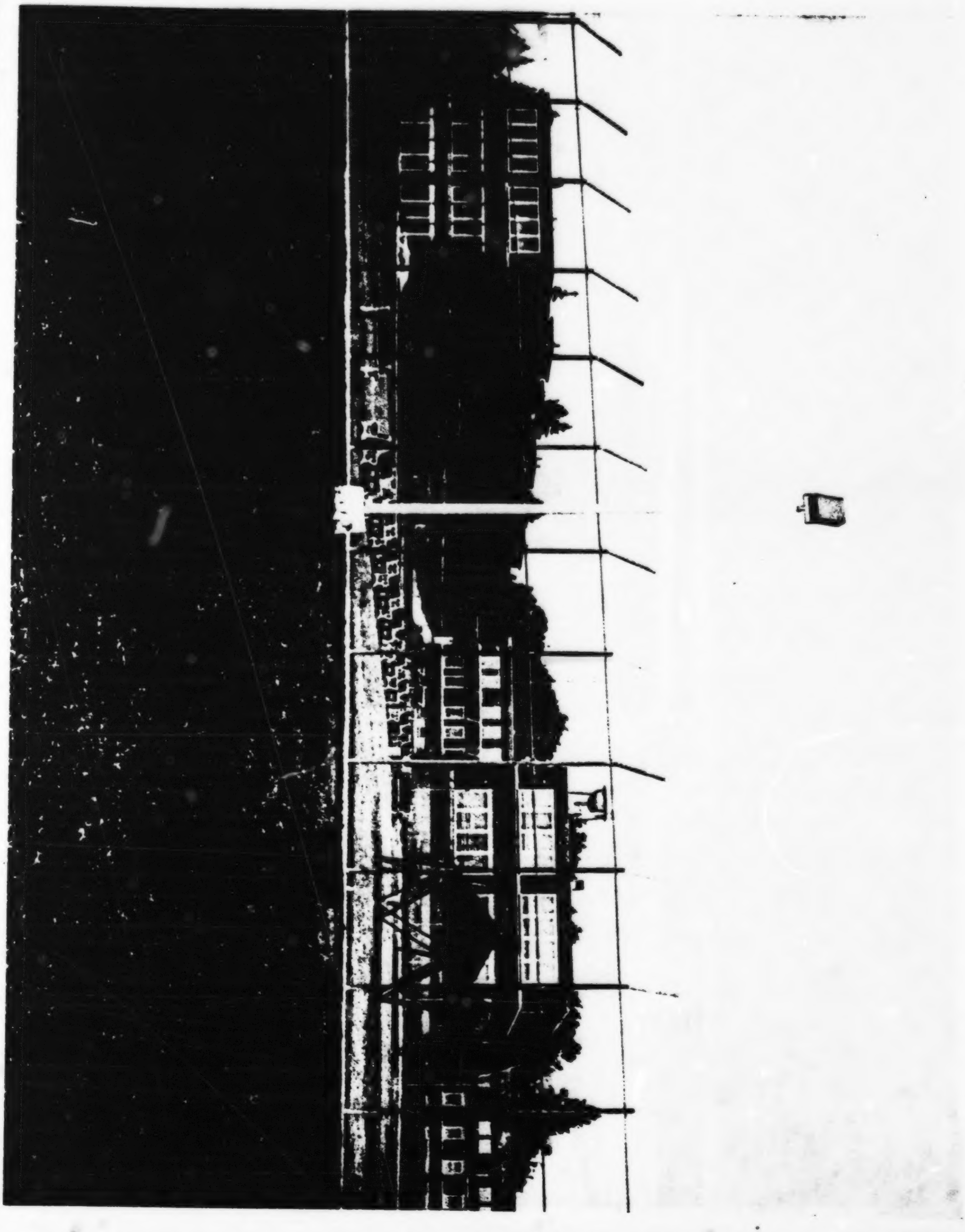


Photo # 4

LOADING AND STORAGE AREAS OF INDUSTRIAL WORKSHOP SHOWN THROUGH PERIMETER FENCE

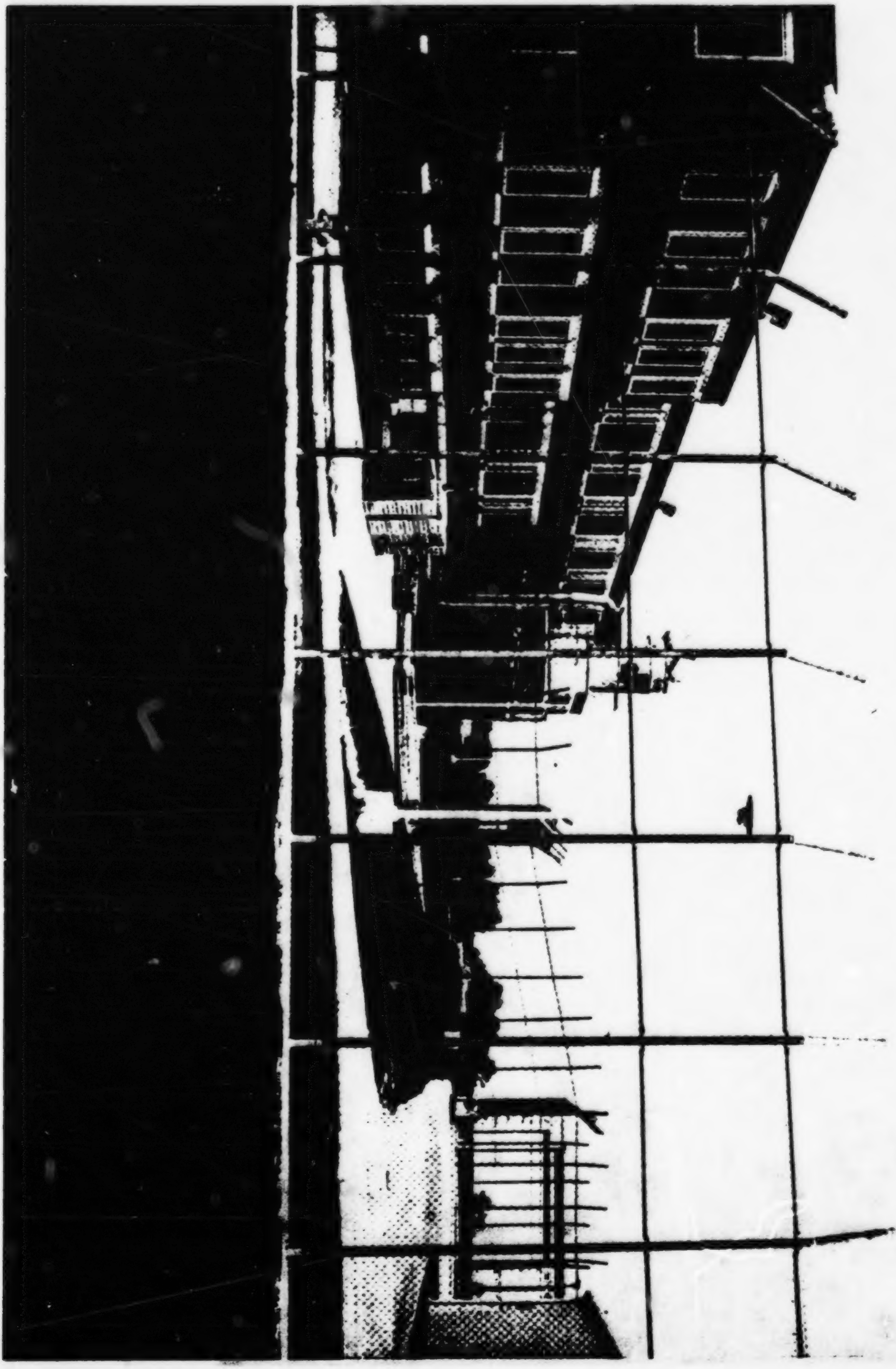


Photo # 5

LOWER WARD CORRIDOR

Photo # 6

SIGNS AT END OF WARD CORRIDOR

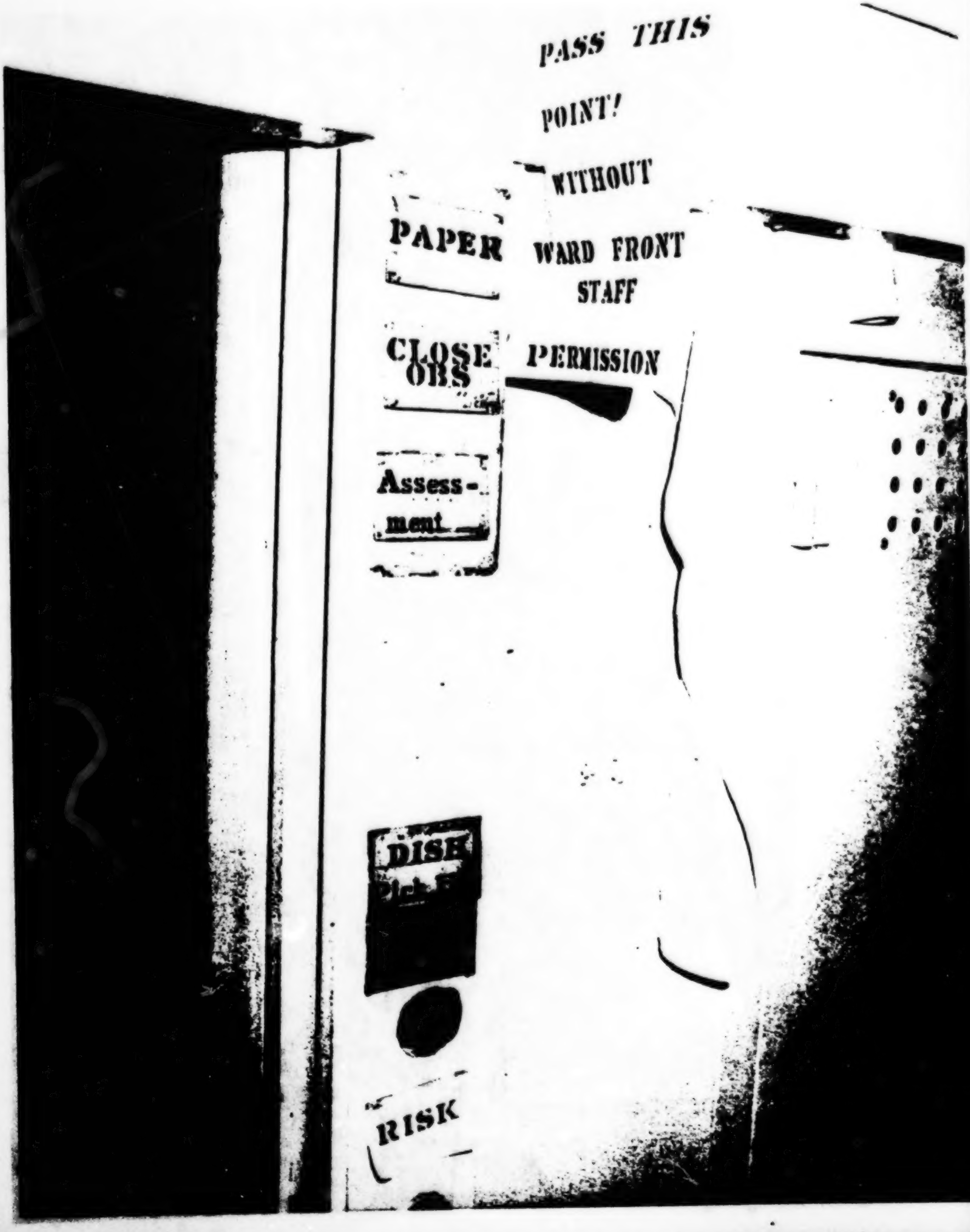

PASS THIS
POINT!
WITHOUT
WARD FRONT
STAFF
PERMISSION
PAPER
CLOSE OBS
Assess-ment
DISH
RISK

Photo # 7

NEWLY FITTED SHOWER STALLS ON THE BEHAVIOUR THERAPHY UNIT

Photo # 8

TOILET FACILITIES IN A PATIENT'S ROOM

Photo # 9

CONCRETE SLAB "BED" IN A PATIENT'S ROOM

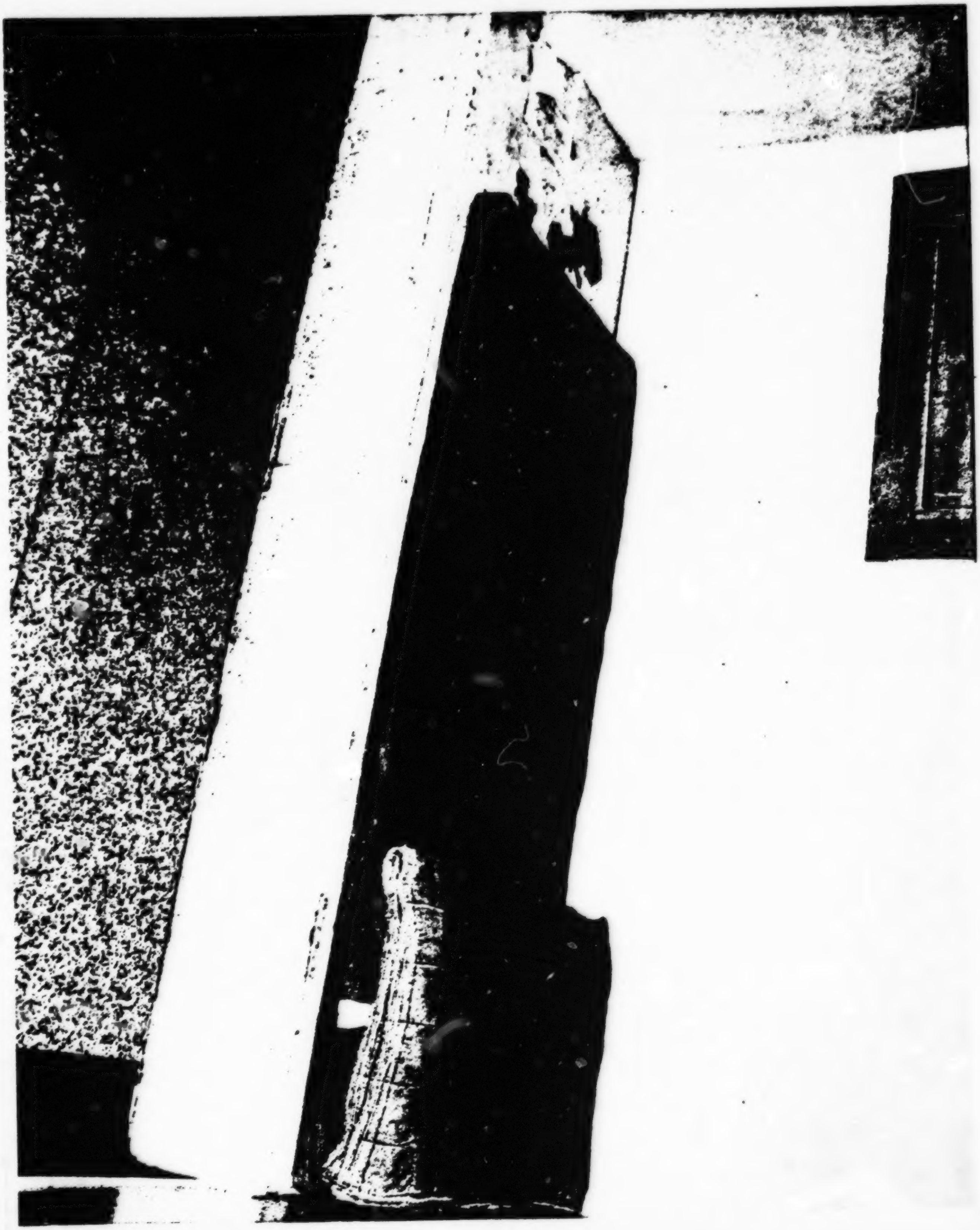
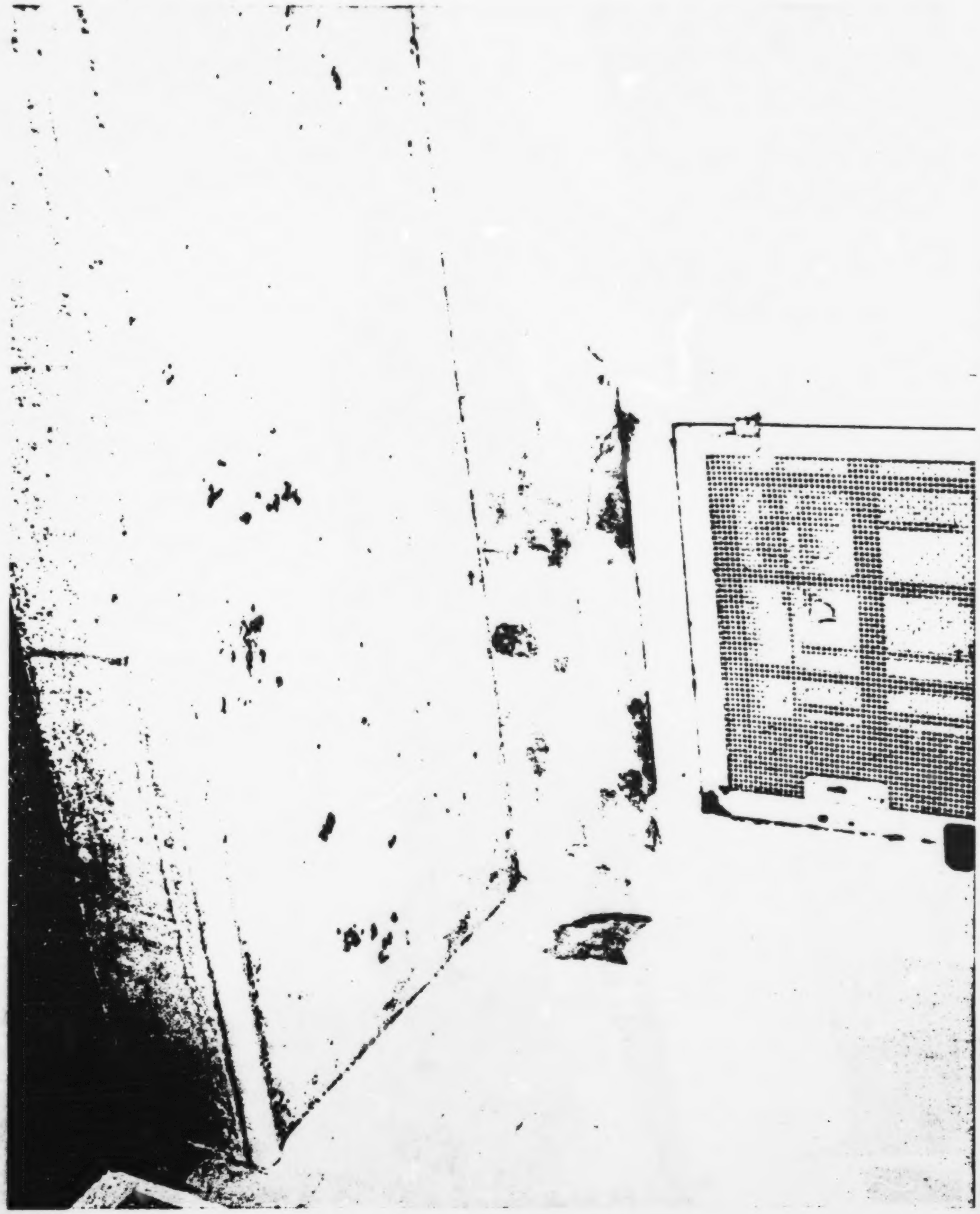


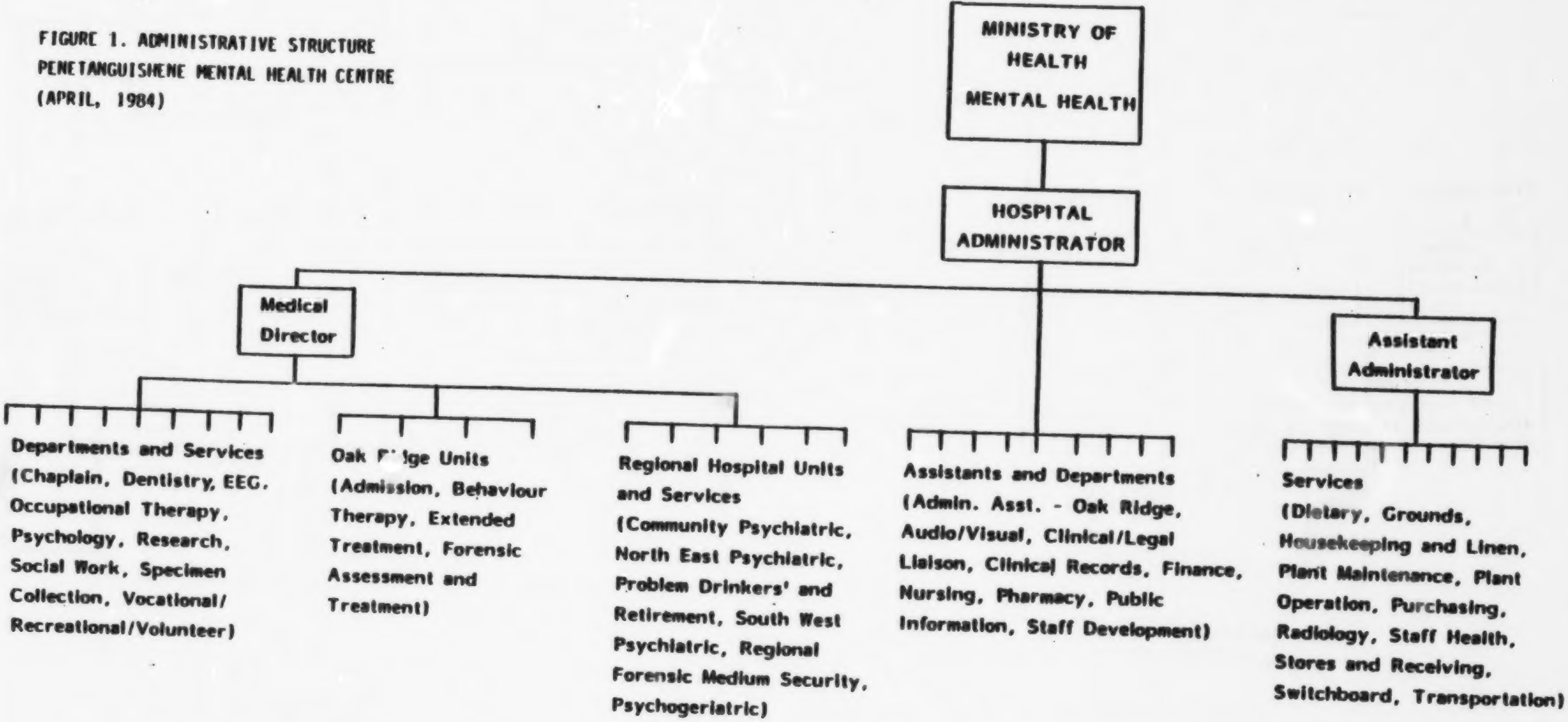
Photo # 10

SCREENED AND BARRED WINDOW
OVER CONCRETE SLAB "BED"



APPENDIX E

FIGURE 1. ADMINISTRATIVE STRUCTURE
PENETANGUISHENE MENTAL HEALTH CENTRE
(APRIL, 1984)


MINISTRY OF HEALTH
MENTAL HEALTH
HOSPITAL ADMINISTRATOR
Medical Director
Assistant Administrator
Departments and Services (Chaplain, Dentistry, EEG. Occupational Therapy, Psychology, Research, Social Work, Specimen Collection, Vocational/ Recreational/Volunteer)
Oak Ridge Units (Admission, Behaviour Therapy, Extended Treatment, Forensic Assessment and Treatment)
Regional Hospital Units and Services (Community Psychiatric, North East Psychiatric, Problem Drinkers' and Retirement, South West Psychiatric, Regional Forensic Medium Security, Psychogeriatric)
Assistants and Departments (Admin. Asst. - Oak Ridge, Audio/Visual, Clinical/Legal Liaison, Clinical Records, Finance, Nursing, Pharmacy, Public Information, Staff Development)
Services (Dietary, Grounds, Housekeeping and Linen, Plant Maintenance, Plant Operation, Purchasing, Radiology, Staff Health, Stores and Receiving, Switchboard, Transportation)

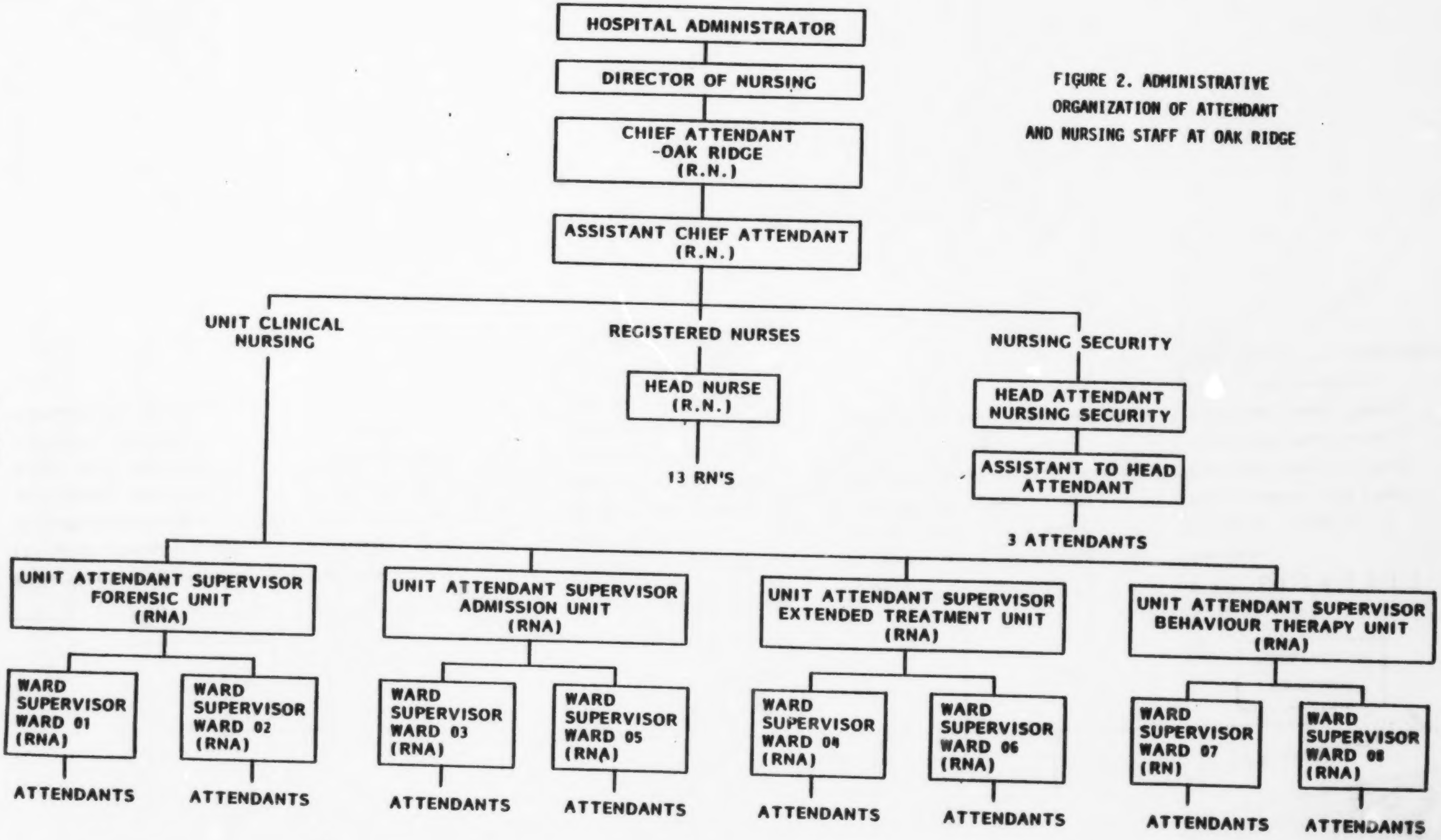

HOSPITAL ADMINISTRATOR
DIRECTOR OF NURSING
CHIEF ATTENDANT -OAK RIDGE (R.N.)
ASSISTANT CHIEF ATTENDANT (R.N.)
UNIT CLINICAL NURSING
REGISTERED NURSES
NURSING SECURITY
HEAD NURSE (R.N.)
13 RN'S
HEAD ATTENDANT NURSING SECURITY
ASSISTANT TO HEAD ATTENDANT
3 ATTENDANTS
UNIT ATTENDANT SUPERVISOR FORENSIC UNIT (RNA)
UNIT ATTENDANT SUPERVISOR ADMISSION UNIT (RNA)
UNIT ATTENDANT SUPERVISOR EXTENDED TREATMENT UNIT (RNA)
UNIT ATTENDANT SUPERVISOR BEHAVIOUR THERAPY UNIT (RNA)
WARD SUPERVISOR WARD 01 (RNA)
WARD SUPERVISOR WARD 02 (RNA)
WARD SUPERVISOR WARD 03 (RNA)
WARD SUPERVISOR WARD 05 (RNA)
WARD SUPERVISOR WARD 04 (RNA)
WARD SUPERVISOR WARD 06 (RNA)
WARD SUPERVISOR WARD 07 (RN)
WARD SUPERVISOR WARD 08 (RNA)
ATTENDANTS
ATTENDANTS
ATTENDANTS
ATTENDANTS
ATTENDANTS
ATTENDANTS
ATTENDANTS
ATTENDANTS

FIGURE 2. ADMINISTRATIVE ORGANIZATION OF ATTENDANT AND NURSING STAFF AT OAK RIDGE

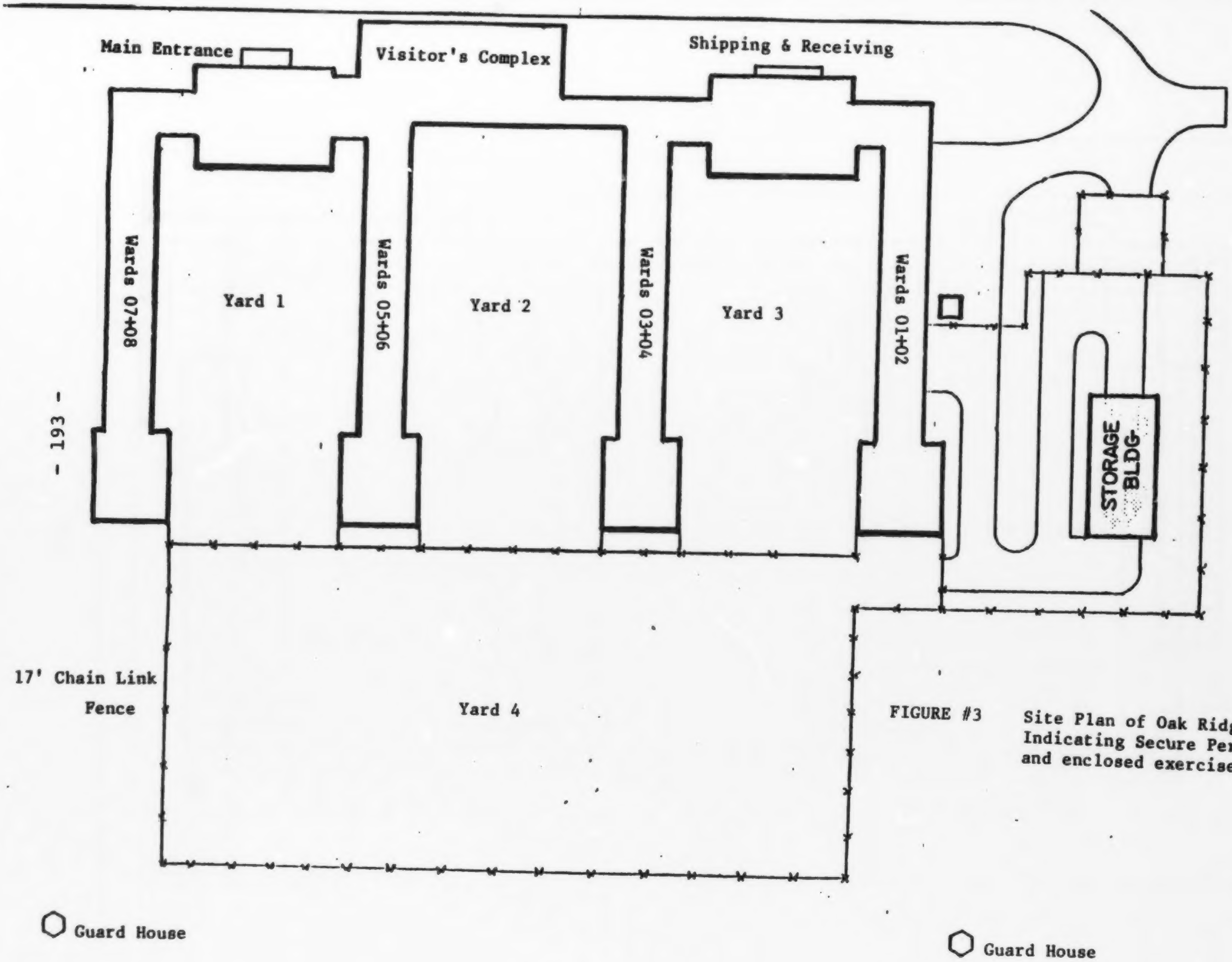

Main Entrance
Visitor's Complex
Shipping & Receiving
Wards 07+08
Yard 1
Wards 05+06
Yard 2
Wards 03+04
Yard 3
Wards 01+02
STORAGE BLDG
17' Chain Link Fence
Yard 4
Guard House
Guard House

FIGURE #3 Site Plan of Oak Ridge Indicating Secure Perimeter and enclosed exercise Yards

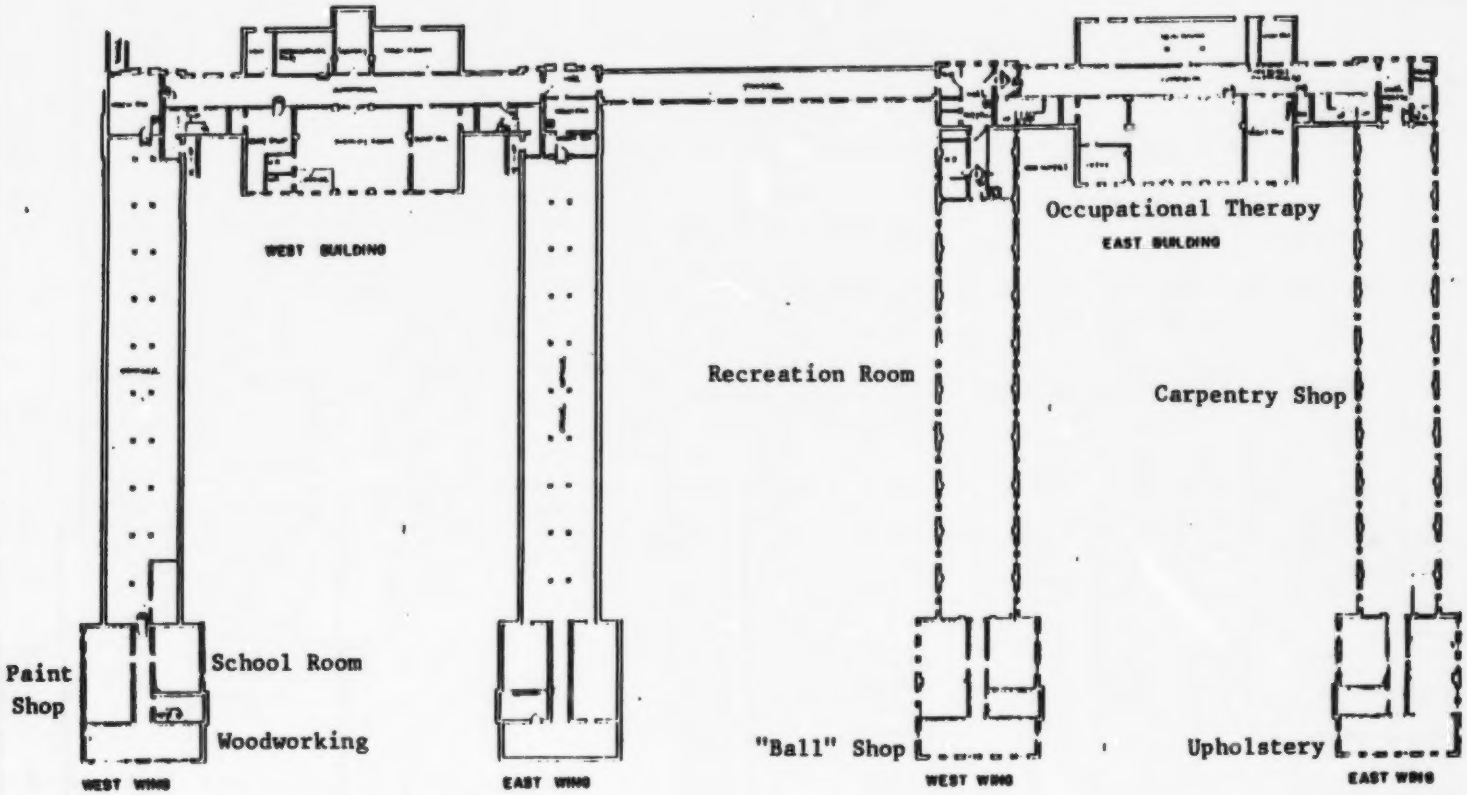

WEST BUILDING
Occupational Therapy
EAST BUILDING
Recreation Room
Carpentry Shop
Paint Shop
School Room
Woodworking
"Ball" Shop
Upholstery
WEST WING
EAST WING
WEST WING
EAST WING

FIGURE 4 Basement Floor Plan

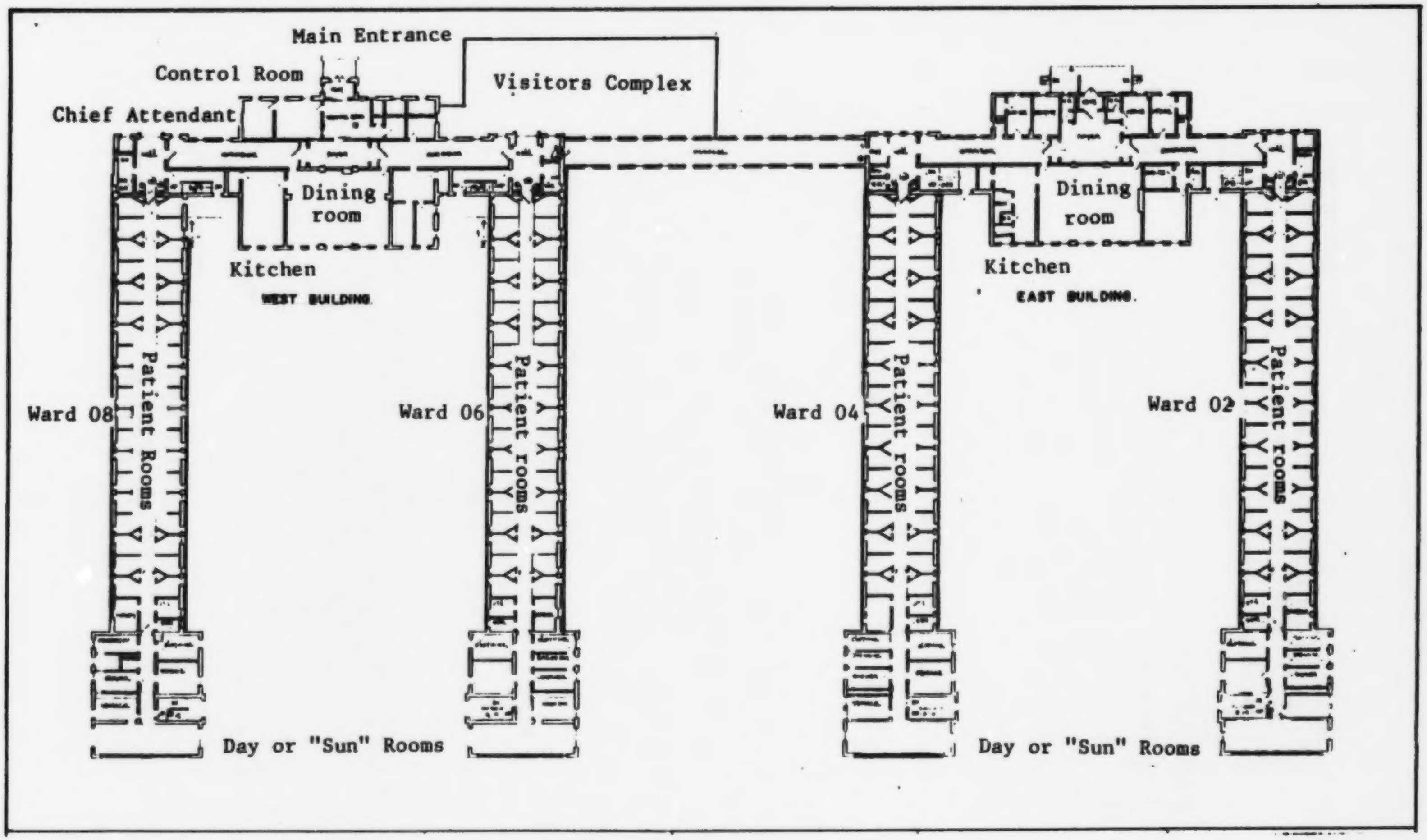

Main Entrance
Control Room
Chief Attendant
Visitors Complex
Dining room
Kitchen
WEST BUILDING
Dining room
Kitchen
EAST BUILDING
Ward 08
Patient Rooms
Ward 06
Patient rooms
Ward 04
Patient rooms
Ward 02
Patient rooms
Day or "Sun" Rooms
Day or "Sun" Rooms

Figure #5 First Floor Plan
Oak Ridge

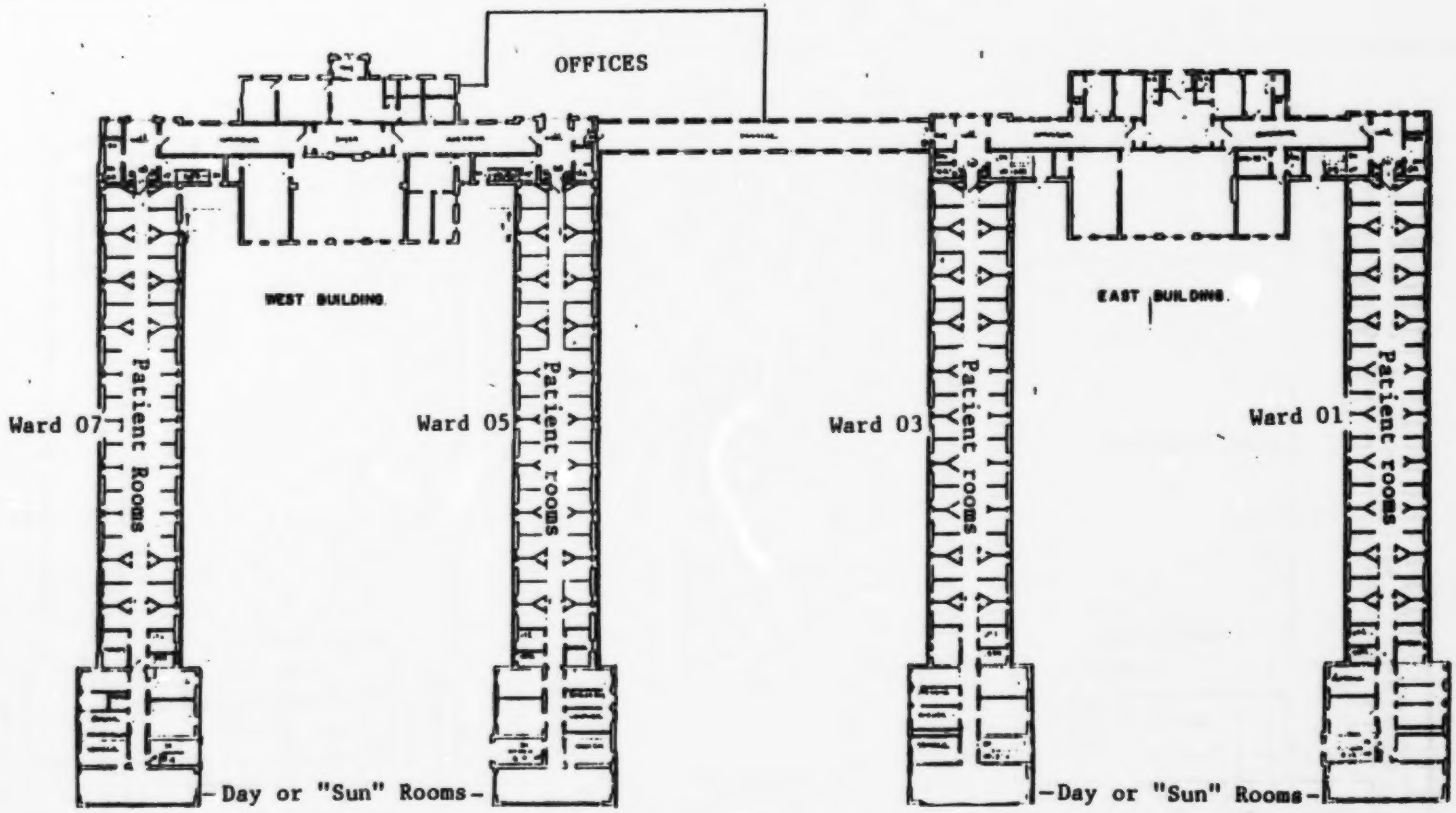

OFFICES
WEST BUILDING
EAST BUILDING
Ward 07
Ward 05
Ward 03
Ward 01
Patient Rooms
Patient rooms
Patient rooms
Patient rooms
-Day or "Sun" Rooms-
-Day or "Sun" Rooms-

Figure #6 Second Floor Plan
Oak Ridge